42-94 5 1
CRF

BIRTH NO. 8520
M.E. CASE NO. 65 5001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5001

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Mary Jones

2. DATE AND HOUR OF DEATH: May 8, 1965 — 8:05 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland, 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 805
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1824 N. Broadway, 21213

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 5-30-1900
9. AGE (In years last birthday): 64
If Under 1 Yr. Months / Days; If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: UNK
14. MOTHER'S MAIDEN NAME: ~~UNK~~ Annie Cotton

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — ADDRESS: RECORDS: BCH, 4940 Eastern Ave., #21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 mo.
DUE TO
(B) Right & Left Cerebral Vascular Accident — 4 mo. & 3 yrs.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED — While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from February 25 19 65 to May 8, 19 65, that (I) (we) last saw the deceased alive on May 8, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Philip Zieve M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: MAY 8, 1965
23C. PHYSICIAN'S NAME (Type): PHILIP ZIEVE M.D.
23D. ADDRESS: 4940 Eastern Ave., Baltimore, Md., 21224

24A. BURIAL CREMATION, REMOVAL (Specify): /Burial
24B. DATE: 5-12-65
24C. NAME of CEMETERY or CREMATORY: Carver, Md.
24D. LOCATION (City, town, or county) (State): Laurel Md.

25A. DATE REC'D BY HEALTH DEPT.: MAY 11 1965
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR — ADDRESS: Morton & Dyett Fun. Home 1701 Laurens

VS 150-REV. 1/1/65

W-6 31

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5002 Registered No. 65 5002

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Ernest H. Wright, Sr.

2. DATE AND HOUR OF DEATH: 5/9/65 6:00 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): Sinai

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balto. 27-17
C. CITY OR TOWN, (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give locotion): 3408 Avondale Ave

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W		11/25/86	78				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Shipping & Receiving Clerk	Janitors Supply	Md.	USA

13. FATHER'S NAME: Thomas Wright

14. MOTHER'S MAIDEN NAME: Annie Elizabeth Doyle

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or (unknown)) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	213-03-8601	Ernest H. Wright, Jr.	3408 Avondale AVE;

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral artery thrombosis — 3 weeks
DUE TO Possible Myocardial Infarction — 2 weeks

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) Arteriosclerotic cardiovascular — years
DUE TO disease

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Bilateral Bronchopneumonia
Severe Congestive Heartfailure — 2 weeks

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/14 19 65 to 5/9 19 65, that (I) (we) last saw the deceased alive on 5/9 19 65 and that in(my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
Donald Rice		☐	☐	☒	5/9/65

23C. PHYSICIAN'S NAME (Type)	M.O.	23D. ADDRESS
Donald Rice		Sinai Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-12-1965	Loudon Park	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 11 1965	Robert E. Farley, M.D.	G. Howard Strong 3207 W. North Ave.,

VS 150-REV. 1/1/65

SAB-31-23-341

X-626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5003 Registered No. 65 5003

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): James Howard Yorker

2. DATE AND HOUR OF DEATH: 5-11-1965 2.30 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 22-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 37 E. York Street 21230

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Negro	Married	6-6-1910	54				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	U.S.A.

13. FATHER'S NAME: George Davis

14. MOTHER'S MAIDEN NAME: Josephine Pelham

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): Yes WW II

16. SOCIAL SECURITY NO.: 213-16-1096

17. INFORMANT: Records: BCH-4940 Eastern Avenue 21224 ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Pharynx — INTERVAL BETWEEN ONSET AND DEATH: 6 months

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-24- 19 65 to 5-11- 19 65, that (I) (we) last saw the deceased alive on 5-11- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Richard Lane M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ — 23B. DATE SIGNED: 5-11-1965

23C. PHYSICIAN'S NAME (Type): Dr. Richard Lane M.D.

23D. ADDRESS: 4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-14-65	Balto. Meth. Cem.	Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: MAY 11 1965 — 25B. NAME OF REGISTRAR: Robert E. Farley, M.D. — 25C. FUNERAL DIRECTOR: George A. Kelso — ADDRESS: 1348 N. Calhoun St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-552 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5004 Registered No. 65 5004

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARIE MUNNINGS

2. DATE AND HOUR OF DEATH: 5-6-65 | 7:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 3-02
D. STREET ADDRESS (If rural, give location): 127 S. Eutaw St

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	Col.	Widow	Jan 11 1906	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic		Towson Md.	

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No -			Leroy Parker	

4-33.1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenio, etc. It means the disease, injury or complication which caused death.)

I (A) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 1-2 hr.
DUE TO
(B) Most probably thrombosis Chronic Atrial Fibrillation
DUE TO
(C) ASCVD

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that I (this hospital) attended the deceased from 4-14-65 19 65 to 5-6- 19 65, that I (we) last saw the deceased alive on 5-6 19 65 and that death (our) opinion death occurred on the date and hour and from the causes stated above. I (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
Robert L. Doyle					5-6-65

23C. PHYSICIAN'S NAME (Type) M.D. 23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	May 11 65	Pleasant Rest Cem.	Towson Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 11 1965	Robert E. Farley, M.D.	Jos. T. Erickson	1129 W. Cathedral St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-500 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5005 Registered No. 65 5005

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BOONE ROOSEVELT

2. DATE AND HOUR OF DEATH: MAY 8, 1965 | 10 20 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY OF MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 14-01
D. STREET ADDRESS (If rural, give location): 1931 Eutaw Place

38

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	N	SEPERATED	4/2/1909	56				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Construction	Ellicott S.C.	U.S.A.

13. FATHER'S NAME: Frank Boone

14. MOTHER'S MAIDEN NAME: Almeta Fisher

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Willie L. Boone ADDRESS: 2522 Quantico Ave.

MEDICAL CERTIFICATION

18. 1547 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not meon the mode of dying, e.g., heort foilure, osthenio, etc. It meons the diseose, injury or complicotion which coused deoth.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if ony, giving rise to the obove cause (A) stoting the UNDERLYING CONDITION lost.

CAUSE OF DEATH

(A) TERMINAL CARCINOMATOSIS
DUE TO
(B) PRIMARY Ca of RECTUM
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED White At Work ☐ Not While At Work ☐	21F. HOW DID INJURT OCCUR?

22. I certify that (I) (this hospital) attended the deceased from MAY 8 1965 to MAY 8 1965, that (I) (we) last saw the deceased alive on MAY 8 1965 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Joseph J. Mowad M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED: 5/8/65

23C. PHYSICIAN'S NAME (Type): Joseph J. Mowad M.D. 23D. ADDRESS:

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERT or CREMATORT	24D. LOCATION (City, town, or county) (State)
Burial	5/12/65	Mt Auburn Cem.	Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 11 1965	Robert E. Fahrney	Herbert E. Nutter 3035 W. North Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-550 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5006 Registered No. 65 5006

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Forest Cannon.

2. DATE AND HOUR OF DEATH: May 9, 1965 | 2.40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 42 Smai Hospital.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 15-13
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 2618 Loyola Northway

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	N	M	8-12-16	48.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chemical Operator	Chromate.	S.C. (Woodruff)	USA.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Cecil Cannon	Mattie McClintic

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES 16 DEC 43 - 8 MAR 46	248-10-6145	Mrs. Madge Cannon	2618 Loyola Northway

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 163X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) DUE TO: Ca. of Lung & metastasis — INTERVAL BETWEEN ONSET AND DEATH: 6 mo.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(B) DUE TO:
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
24-7-65	Ca of Lung	Yes.	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-5 1965 to 5-9 1965, that (I) (we) last saw the deceased alive on 5-9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☑	23B. DATE SIGNED
Lawrence Solomon					5-9-65.

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Lawrence Solomon M.D.		Smai Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/14/65	Baltimore National Cem.	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 11 1965	Robert E. Faber, M.D.	Herbert E. Nutter	3035 W. North Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

43-03-36 AM
C-540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5007 Registered No. 65 5007

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Eleanor Theresa Connelly

2. DATE AND HOUR OF DEATH: 5-11-65 1:00 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 9-07
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1536 East 28th. Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Single	6-7-85	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	U. S. A.

13. FATHER'S NAME: WILLIAM V. CONNELLY

14. MOTHER'S MAIDEN NAME: SARAH C. KELLY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	215074922 A	RECORDS: B.C.H.	4940 Eastern Avenue #21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
I (A)	Myocardial Infarction	?
DUE TO (B)	Arteriosclerotic Cerebral Vascular Disease	?
DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Multiple Cerebral Vascular Accidents	

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-8- 19 65 to 5-11- 19 65, that (I) (we) last saw the deceased alive on 5-11- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
Philip Zieve M.D.	Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒	5-11-65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Dr. Philip Zieve M.D.	4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/15/65	St. Joseph Cemetery	Texas, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 11 1965	Robert E. Farley M.D.	LEONARD J. RUCK, INC., BALTO., MD. 21214

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.
M.E. CASE NO. 65 5008

Registered No. 65 5008

1. NAME OF DECEASED (Type or Print): ROBERT H. KELLER

2. DATE AND HOUR OF DEATH: 5-10-65 | 5.40 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: 27-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE, 14
D. STREET ADDRESS (If rural, give location): 5104 HARFORD RD.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	WHITE	MARRIED	2-20-91	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Barber		Md.	U.S.A.

13. FATHER'S NAME: FRANK KELLER

14. MOTHER'S MAIDEN NAME: KATE DONTELL

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs. Clara Keller	Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Septicemia
DUE TO
(B) Gangrene @ leg
DUE TO
(C) Diabetes Mellitus

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Lipodactyzed Cutaneous fistula

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
3/26/65	Ca of larynx	yes	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 1 1965 to MAY 10 1965, that (I) (we) last saw the deceased alive on May 9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
E. C. Holmes					5/10/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
DR. E. C. HOLMES		Johns Hopkins Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/14/65	New Cathedral Cemetery	Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 11 1965	Robert E. Farley, M.D.	L. J. Ruck-Parlor	

VS-130-REV. 4/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-4521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. / M.E. CASE NO. 65 5009 — Registered No. 65 5009

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Joseph M. Bollinger
2. DATE AND HOUR OF DEATH: May 8, 1965. M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND
   - FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): 1710 33rd. Street
4. USUAL RESIDENCE (Where deceosed lived, If institution: residence before odmission)
   - A. STATE: Md.
   - B. COUNTY: 902
   - C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
   - D. STREET ADDRESS (If rurol, give locotion): 1710 33rd. Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In yeors lost birthdoy)	If Under 1 Yr. Months / Doys	If Under 24 Hrs. Hours / Min.
Male	White	Widowed	March 8, 1882	83		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	P.R.R.	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles F. Bollinger	Virginia Crews

15. Was Deceosed Ever in U. S. Amed Forces? (Yes, no or unknown) (If yes, give wor or dotes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	217140139	Mrs. Sadie R. Bollinger	

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. 1B. 334 X — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) DUE TO: Hypostatic pneumonia	1 wk
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(B) DUE TO: Generalized arteriosclerosis	3 yrs
	(C) Cerebral arteriosclerosis.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or obout home, form, foctory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Boltimore City, give exoct locotion)

21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify thot (I) (this hospitol) ottended the deceased from Sept 19 64 to 5/8 19 65, thot (I) (we) lost sow the deceosed olive on 5/7 19 65 ond thot in (my) (our) opinion death occurred on the dote ond hour ond from the couses stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
Conrad L. Richter					5/10/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Conrad L. Richter M.D.	3128 Harford Rd Balto 18 Md

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/11/65	Woodlawn Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 11 1965	Robert E. Fahey M.D.	Leonard J. Ruck, Inc.,	Balto., Md.

VS 150-REV. 1/1/65

E-242 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5010 Registered No. 65 5010

1. NAME OF DECEASED (Type or Print): Emma M. Eckels

2. DATE AND HOUR OF DEATH: May 10, 1965. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 2303 Mayfield Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 8-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #13
D. STREET ADDRESS (If rural, give location): 2303 Mayfield Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Widow	July 12, 1883	81				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Braun	Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	220-44-1687	Mr. August E. Eckels	(Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
420.1
(A) Chronic arteriosclerosis
DUE TO
(B) of the heart (Myocardial infarction) — 1 mo.
DUE TO
(C) Coronary heart disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLTING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURT (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURT OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURT OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 1 1965 to May 10 1965, that (I) (we) last saw the deceased alive on May 10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: F. Frederick Ruzicka M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐ — 23B. DATE SIGNED: 5/10/65

23C. PHYSICIANS NAME (Type): DR. F. F. RUZICKA M.D. — 23D. ADDRESS: 800 N. Patterson Park Ave

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/12/65	Parkwood Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 11 1965	Robert E. Farber, M.D.	Leonard J. Ruck Inc. Balto. Md. 21214

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-2301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5011 Registered No. 65 5011

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Mazziott, John Frank

2. DATE AND HOUR OF DEATH: 5/9/65 | 9:40 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 91 Montebello State Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-06
D. STREET ADDRESS (If rural, give location): 2705 Hemlock Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	Married.	2/18/06	59				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Milk salesman		Maryland	U.S.A.

13. FATHER'S NAME: Frank Mazziott

14. MOTHER'S MAIDEN NAME: Rose Spinato

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		213-01-4819	Caroline Mazziott	S/A

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 193.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: cardiac arrest

(B) DUE TO: intracranial pressure

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C): sarcoma, brain — INTERVAL BETWEEN ONSET AND DEATH: 3 mo.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
—

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		yes	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/5 1965 to 5/9 1965, that (I) (we) last saw the deceased alive on 5/9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Robert W. Ireland M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 5/9/65

23C. PHYSICIAN'S NAME (Type): Robert W. Ireland M.D.

23D. ADDRESS: Montebello State Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/13/65	Holy Redeemer Cem.	Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 11 1965	Robert E. Farley, M.D.	Leonard J. Ruck, Inc.	Balto. #14

VS 150-REV. 1/1/65

A-260 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5012 Registered No. 65 5012

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Nunzia Assero

2. DATE AND HOUR OF DEATH: May 9, 1965. 3 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): 2907 Markley Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 2702
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 14
D. STREET ADDRESS (If rurol, give location): 2907 Markley Ave.

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH: 6/9/1889
9. AGE (In years last birthday): 75
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? Italy

13. FATHER'S NAME: Joseph DePasquale
14. MOTHER'S MAIDEN NAME: ~~xxxxxxxx~~ Michaelina Salerno

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 214140732B
17. INFORMANT ADDRESS: Mrs. Dolores Walsh, 4506 Hampnett Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
I (A) DUE TO	Cerebral Hemorrhage	3 hours
(B) DUE TO	Arterial Hypertension	5 Years
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1936 19 to 5-9-65 19, that (I) (~~we~~) last saw the deceased alive on 5-8-65 19 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: G. W. Peake M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 5-11-65
23C. PHYSICIAN'S NAME (Type): G. W. PEAKE M.D.
23D. ADDRESS: 4508 Harford Rd, Balto 14 Md

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 5/13/65
24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.: MAY 11 1965 Roberts
25B. NAME OF REGISTRAR: E. Farley M.D.
25C. FUNERAL DIRECTOR ADDRESS: Leonard J. Ruck, Inc., Balto., Md.

VS 150-REV. 1/1/65

R-235 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5013 Registered No. 65 5013

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Royston, Amos M.

2. DATE AND HOUR OF DEATH: 5-8-65 1:00 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Maryland General

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Carroll
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Westminister 56-00
D. STREET ADDRESS (If rural, give location): 256 E Green St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	CAU.	Married	11-27-06	58				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic	Coca-Cola Bottling Co. Mechanic	Maryland	USA

13. FATHER'S NAME: William Royston

14. MOTHER'S MAIDEN NAME: CARRIE Gettier.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	NO	212-16-4817	Mrs Edith D. Royston Wife	2562 Thurm St. Westminster Md.

MEDICAL CERTIFICATION

18. 3301 1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: ~~Pneumonia~~ ~~Embolism~~ Aspiration pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: ~~1 hr.~~

(B) DUE TO: ~~Aspiration~~ Ruptured appendix — 12 days ~~hr. min.~~

(C) ~~Ruptured Appendix~~ — ~~2 hrs.~~

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Pulmonary emphysema Bronchial Astma. — Yrs.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
5/1	Peritonitis	Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/1 19 65 to 5/8 19 65, that (I) (we) last saw the deceased alive on 5/8 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
Thomas M Hudak		☐	☐	☑	5/8/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Thomas Hudak		Maryland General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/11/65	Leisters Cemetery	Rural Near Westminster, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 11 1965	Robert E. Foster M.D.	J. E. Myers Jr. Westminster, Md.

VS 150-REV. 1/1/65

R 3501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5014 Registered No. 65 5014

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Henrietta Rodney

2. DATE AND HOUR OF DEATH: 5/8/65 12 45 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hospital for the Women of Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 11-03
C. CITY OR TOWN (If outside city limits; write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 873 North Howard St.

5. SEX: Female 6. RACE: White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 12-15-1865 9. AGE (In years last birthday): 99 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HouseWife 10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Rock Hall, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Wrie

14. MOTHER'S MAIDEN NAME: Susan Matilda Scully (Scully)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Ethel Rodney Tracy ADDRESS: 873 North Howard St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not meon the made of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complicotion which coused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the obave cause (A) stating the UNDERLYING CONDITION last.

I

(A) Dehydration 2° to
DUE TO
(B) Generalized ASCVD, Senility
DUE TO
(C) & Debility.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)

21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-7 1965 to 5-8 1965, that (I) (we) last saw the deceased alive on 5-8 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Diadema B. Simon M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED: 5-8-65

23C. PHYSICIAN'S NAME (Type): DIADEMA B. SIMON M.D. 23D. ADDRESS: HOSP. FOR THE WOMEN OF BALTIMORE

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL 24B. DATE: MAY 10 24C. NAME of CEMETERY or CREMATORY: Wesley CHAPEL 24D. LOCATION (City, town, or county) (State): ROCK HALL MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: MAY 11 1965 25B. NAME OF REGISTRAR: Robert E. Fahrney M.D. 25C. FUNERAL DIRECTOR: Edgar L. Kane ADDRESS: CHURCH HILL MD.

VS 150-REV. 1/1/65

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5015 — Registered No. 65 5015

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Margaret Louise Beard — MARGARET LOUISE BEARD

2. DATE AND HOUR OF DEATH: 5-5-65 | 7:20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY: Frederick
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Frederick — 60-00
D. STREET ADDRESS (If rural, give location): Rocky Ridge

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	M	1-15-32	33		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Maryland	USA.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Daniel A. Fogle	Mildred M. ~~Fitz~~ Fietz

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	217-28-6328	Husband. William Beard	-S/A

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.): Rheumatic Heart Disease C. — 27 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

DUE TO: Aortic & Mitral Valvulitis & Congestive Heart Failure.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Mitral & Aortic Valve Involvement - 5-5-65 — 12 Hrs.

CERTIFICATION APPROVED BY: [signature] M.D. CHIEF MEDICAL EXAMINER. 5/7/65

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
5-5-65	Aortic & Mitral Insuffic.	NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-15 1965 to 5-5 1965, that (I) (we) last saw the deceased alive on 5-5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
N. W. Todd Jr.					5-5-65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Nevins W. Todd, Jr.		University Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-9-54	Mt. Tabor Cemetery	Rocky Ridge Fred. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 11 1965	[signature]	Raymond E. Creager, Thurmont Md.	

VS 150-REV. 1/1/65

Released By Medical Examiner - Dr. Petty On Appeal

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

BIRTH NO. M.E. CASE NO. 65 5016 — Registered No. 65 5016

1. NAME OF DECEASED (Type or Print): BROWN, HARMON N.

2. DATE AND HOUR OF DEATH: 5/4/65 | 7:45 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): 38 Unweriuty Hoiputal

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Calvat
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Dowell 5700
D. STREET ADDRESS (If rural, give location): Dowel Post Offuca

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	Separated	1/2/88	77				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter - RET
10B. KIND OF BUSINESS OR INDUSTRY: Building
11. BIRTHPLACE (State or foreign country): Michigan
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: — Unknown
14. MOTHER'S MAIDEN NAME: Ella Allcid

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) Unknown (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Hoipital Lecords ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 2240 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart foilure, osthenia, etc. It means the diseose, injury or complicotion which coused death.)
(A) Chronic Lymphocytic Leukemia — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the obove cause (A) stoting the UNDERLYING CONDITION lost.
(B) DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		?	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Boltimore City, give exoct locotion)

21D. TIME OF INJURY (Month) (Doy) (Yeor) (Hour) (APPROX.)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 4 1965 to May 4 1965, that (I) (we) last saw the deceased alive on May 4 1965 and that in (my) (our) opinion death occurred on the date and hour and from the couses stoted above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Barry N. Rosenbaum M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 5/4/65
23C. PHYSICIAN'S NAME (Type): BARRY N. ROSENBAUM M.D.
23D. ADDRESS: Unweriuty Hoipital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/11/65	Parklawn Cemetery	Rockville, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 11 1965	Robert E. Farley M.D.	Robert A. Pumphrey, Bethesda, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-220 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5017 — Registered No. 65 5017

1. NAME OF DECEASED (Type or Print): KIEZISS, MRS. MARCELA
2. DATE AND HOUR OF DEATH: May 9, 1965 | 7:55 A M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home and Hospital
4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) — A. STATE: Maryland — B. COUNTY: 3 — C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore — D. STREET ADDRESS (If rural, give location): 301 S. Ballow Court

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	white	married	Dec. 25, 1892	72				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
house wife		Lithuania	USA

13. FATHER'S NAME: Augustus Trimas
14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 217-22-8752
17. INFORMANT: Patricia Saunder — ADDRESS: 401 Moreland Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 260 X 1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
DUE TO (B) generalized arterio sclerosis — years
DUE TO (C) diabetes mellitus — years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED — While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 25 1965 to May 9 1965, that (I) (we) last saw the deceased alive on May 9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE				23B. DATE SIGNED
José S. Maisog M.D. M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☑	May 9, 1965

23C. PHYSICIAN'S NAME (Type): José S. Maisog M.D. M.D.
23D. ADDRESS: Church Home and Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-12-65	Balto. National	Fredrick Ave. MD.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 11 1965	Robert E. Farber, M.D.	Wm. S. Fralkowski	2007 Eastern Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-612 1

BIRTH NO. 65 5018

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 5018

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): EDWARD BROFKA

2. DATE AND HOUR OF DEATH: 5-10-65 | 2 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH HOME & HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 3-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 518 S. BETHEL ST.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	M	12-10-1906	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
INSPECTOR	ASARCO HEALTH PLAN	POLAND	[redacted] U.S.A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
MICHAEL [redacted] BROFKA	TAFILA TAPUC [redacted]

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
UNKNOWN	213-03-1764	Teresa Brofka WIFE	518 S. Bethel St. Zone 31 see above

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I (a) TERMINAL CA, with metastasis
DUE TO (b) to the bone, primary from Ca of Colon
DUE TO (c)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY: [signature] M.D. CHIEF OR ASSISTANT MEDICAL EXAMINER.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
4-5-65	Fracture Hip	NO	

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Home	Bathroom - home

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-4-65 19 to 5-10-65 19, that (I) (we) last saw the deceased alive on 5-10-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
Manuel J. Tan M.D.	☐	☐	☒	5/16/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
MANUEL J. TAN, M.D.	CHURCH HOME AND HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-13-65	Holy Cross	A. A. Co. Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 11 1965	Robert E. Farber M.D.	Wm. S. Fialkowski	2007 Eastern Ave

VS 150-REV. 1/1/65

E-524 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5019 Registered No. 65 5019

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) (Mrs.) ~~ANNIS~~ MARY ENGEL

2. DATE AND HOUR OF DEATH May 8, 1965 | 7:03 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give sheet address or location) 91 MONTEBELLO STATE HOSP

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD B. COUNTY Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 7 5300
D. STREET ADDRESS (If rural, give location) 6114 Sunny Lane

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED (WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years) (Last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W		May 21, 1879	85				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	OWN HOME	MARYLAND	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
THOMAS ALBAUGH	ELIZA BROWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
not known	NONE	DR GUERRERO	BALTIMORE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
I (A) DUE TO	Acute Ord. Edema	Recent
(B) DUE TO	Arteriosclerotic Heart Dis.	+ 10 yrs
(C)	Senility	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 13 19 65 to May 8 19 65, that (I) (we) last saw the deceased alive on May 8 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☑	23B. DATE SIGNED
Reuben C Guerrero					5/8/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
REUBEN C. GUERRERO		Montebello State Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or County) (State)
BURIAL	5/11/65	BEAVER DAM	FREDERICK Co MD

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 11 1965	Robert E. Fahrney	D D Hartzler & Sons	Union Bridge Md

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

M-262

BIRTH NO. 65 5020

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5020

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) GORDON MESSERSMITH	2. DATE AND HOUR PRONOUNCED DEAD May 7, 1965 5:10 P M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-08 D. STREET ADDRESS (If rural, give location) 3812 Bank Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	Feb. 8, 1909	56				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Aircraft.	Minnesota.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George P. Messersmith	Angeline Schriber

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	W.W. 2	468-16-9396	Olive Messersmith	3812 Bank St. Baltimore 24, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 422.1

(A) Arteriosclerotic Cardiovascular Disease.

ANTECENDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B)

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S Petty M.D.

EXAMINER'S NAME (Type) Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 5/8/65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/10/65	Laurel Hill	Moscow Mills Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 11 1965	Robert E. Farley, M.D.	E. J. Boal	Westernport, Md.

VS 151-REV. 1/1/65

K-200 1

BIRTH NO. 65 5021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5021

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): RUSSELL I. KESS SR

2. DATE AND HOUR OF DEATH: 5-11-1965 | 10:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): LUTHERAN

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: 16-08
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 3712 Edmondson Ave

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	COLORED	SEPARATED	8/24/1898	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LABORER	BENDIX RADIO	A.A. Co. MD	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
COLOMBUS KESS	REBECCA RICHARDS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	213-10-8613	EMMA CLEMONS	3712 EDMONDSON AVE

MEDICAL CERTIFICATION

18. 4201 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if ony, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO	ACUTE MYOCARDIAL INFARCTION	24 hrs
(B) DUE TO	CORONARY ARTERIOSCLEROSIS	10 yrs.
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospitol) attended the deceased from 5-10 1965 to 5/11 1965, that (I) (we) last saw the deceased alive on 5-10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
Norman R. Kleiman M.D.	Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐	5/11/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
NORMAN R. KLEIMAN M.D.	3803 EDMONDSON AVE

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/15/65	Mt Zion Church	Magothy a.a.Co. Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 12 1965	Robert E. Faber M.D.	Marshall P. Hayes	438 Gilmor St

VS 150-REV. 1/1/65

43-17-25 IB 1

R-162

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5022 Registered No. 65 5022

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Regina Roberg

2. DATE AND HOUR OF DEATH: 5-10-65 4:30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland #21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 24-04
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 210 E. Barney Street - #21230

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widowed	12-9-99	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Maryland	USA

13. FATHER'S NAME: Joseph Kenny

14. MOTHER'S MAIDEN NAME: Cecelia

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		RECORDS-BCH-4940 Eastern Avenue - #21224	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 4 22.1 I 260 X

(A) Cerebral Vascular Accident

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

DUE TO (B) Arteriosclerotic Cardio Vascular Disease

DUE TO (C)

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Diabetes

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-24 19 65 to 5-10 19 65, that (I) (we) last saw the deceased alive on 5-10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
Philip Zieve M.D.	Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒	5-10-65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Dr. Philip Zieve M.D.	BCH-4940 Eastern Avenue - #21224

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5 14 65	Cedar Hill	Brooklyn, A. A. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 12 1965	Robert E. Farley M.D.	Mc Cully	130 E. Fort Ave

VS 150-REV. 1/1/65

5-315 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5023 Registered No. 65 5023

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mr. Biagio D. Stefanelli

2. DATE AND HOUR OF DEATH: 5-8-65 2:35 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore 11-04
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21227
D. STREET ADDRESS (If rural, give location): 1138 Linden Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	Married	Jan. 2, 1900	65				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Presser	Raleigh Mfg. Co.	Italy	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Salvatore Stefanelli	Vita Antonaci

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		191-03-6853	Mrs. Mary E. Stefanelli	1138 Linden Ave-27

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
1B. 420.1 I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cardiac Failure	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	DUE TO (B) Myocardial Infarction	
	DUE TO (C) Coronary Heart Disease	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 7 19 65 to May 8 19 65, that (I) (we) last saw the deceased alive on May 8 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☑	23B. DATE SIGNED
Jose V. de Leon, Jr.					May 8, 1965

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
JOSE V. DE LEON, JR.		Bon Secours Hospital, Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-11-65	Loudon Park	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 12 1965	Robert E. Farley, M.D.	Howard H. Hubbard-4107 Wilkens Ave-21229

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Z-565 1

BIRTH NO. 65 5024

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 5024

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): ZIMMERMAN, MILLARD IRVIN

2. DATE AND HOUR OF DEATH: MAY 7, 1965 11:45 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location): ST. AGNES HOSPITAL BALTO. 29, MD.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): 808 FRANCIS AVENUE BALTIMORE 27
D. STREET ADDRESS (If rural, give location): 52-00

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
MALE	WHITE	MARRIED	3-31-01	64				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FREIGHT AGENT	B AND O R.R.	BALTIMORE, MD.	USA

13. FATHER'S NAME: DANIEL ZIMMERMAN

14. MOTHER'S MAIDEN NAME: MAUDE GAWTHROP

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	705-03-4063	Mrs. MARION G. ZIMMERMAN	ST. AGNES RECORDS 808 FRANCIS AVE-21227

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not meon the mode of dying, e.g., heart failure, osthenio, etc. It meons the diseose, injury or complication which coused deoth.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the obove couse (A) stoting the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
I (A) DUE TO	Carcinoma of the pancreas	
(B) DUE TO	Metastasis to (1)	
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospitol) ottended the deceased from APRIL 22 19 65 to MAY 7 19 65, that (I) (we) lost sow the deceased olive on MAY 7 19 65 ond thot in (my) (our) opinion deoth occurred on the dote ond hour and from the couses stoted obove. (I) (We) (did) (did not) view the body ofter deoth.

23A. SIGNATURE		23B. DATE SIGNED
Millard Shipley M.D.	Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐	5-7-65
23C. PHYSICIAN'S NAME (Type) M.D.	23D. ADDRESS St. Agnes Hosp.	

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-11-65	Mt. Olivet	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 12 1965	Robt E. Fahs, M.D.	Howard H. Hubbard-4107 Wilkens Ave-21229

VS 150-REV. 1/1/65

H-1251

BIRTH NO. 65 5025

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5025

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): HOPKINS ROSE

2. DATE AND HOUR OF DEATH: May 7, 1965 | 3:30 pm M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): 420 N. Madeira Street 21231

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 6-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 420 N. Madeira Street 21231

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
female	white	married	June 6, 1886	78				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Inspector	F.O. Mitchell Bro.	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: Frank Hudecek

14. MOTHER'S MAIDEN NAME: Anna Zahorauska

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		219-07-8111	John F. Hopkins husband	above

MEDICAL CERTIFICATION

18. 490 X I — CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Bronchopneumonia — 1 wk

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO:

(C):

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Chronic Congestive Heart Failure — several years

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED — While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from ____ 19 60 to 7 May 19 65, that (I) (we) last saw the deceased alive on 7 May 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Jaroslav Hulla M.D. — Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐ — 23B. DATE SIGNED: 10 May 65

23C. PHYSICIAN'S NAME (Type): Jaroslav ~~Jaroslab~~ Hulla M.D. — 23D. ADDRESS: 2214 East Fayette Street 21231

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/11/65	Holy Redeemer Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 12 1965	Robert E. Faulkner	Schimunek Funeral Home, Inc.	2601-03-05 E. Madison Street #5

VS 150-REV. 1/1/65

M-640 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5026 Registered No. 65 5026

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARLEY Mr ALBERT Edward

2. DATE AND HOUR OF DEATH: 5/10/65 8.50 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitof or institution, give street address or location): Church Home & Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY: 26-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 6
D. STREET ADDRESS (If rural, give location): 4826 Clayburg Ave

5. SEX: male
6. RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 11-12-02
9. AGE (In years last birthday): 62
If Under 1 Yr. Months / Days; If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Power Plant Opr.
10B. KIND OF BUSINESS OR INDUSTRY: Retired Balto. Gas & Elect.
11. BIRTHPLACE (State or foreign country): Md Baltimore
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Marley
14. MOTHER'S MAIDEN NAME: Theresa Fitzenberger

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 215-07-2126
17. INFORMANT: Marlene Warren, dght. above ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 522.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not meon the mode of dying, e.g., heart foilure, osthenio, etc. It means the diseose, injury or complicotion which coused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, il ony, giving rise to the obove couse (A) stoting the UNDERLYING CONDITION lost.

(A) DUE TO: Congestive heart failure
(B) DUE TO: Chronic Emphysema
(C): Arteriosclerotic heart disease

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/22/65 19 to 5/10/65 19, that (I) (we) last saw the deceased alive on 5/10/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Antoine Arrage M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 5/10/65
23C. PHYSICIAN'S NAME (Type): ANTOINE ARRAGE M.D.
23D. ADDRESS: Church Home & Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 5/14/65
24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: MAY 12 1965
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR ADDRESS: Schimunek Funeral Home, Inc. 3331 Brehms Lane

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-520 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5027 Registered No. 65 5027

1. NAME OF DECEASED (Type or Print): FRANK ALBERT SAMSKI

2. DATE AND HOUR OF DEATH: May 10, 1965 | 4 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Public Health Service Hospital, Wyman Pk. Drive & 31st Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 8-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3121 Bel Air Road

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	Single	7/28/90	74				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	USN	Md. Baltimore	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Andrew Samski	Sophia ~~Bolkack~~ Pawlak

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	USN 1925-1933	220-44-5607	Records- US PHS Hospital, Balto, Md.	

MEDICAL CERTIFICATION

18. 023 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not meon the mode of dying, e.g., heort foilure, osthenio, etc. It meons the disease, injury or complicotion which coused deoth.)	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
	(A) Ruptured aortic aneurysm	Several hours
ANTECEDENT CAUSES	(B) DUE TO Luetic aortitis	Years
DISEASES OR CONDITIONS, if ony, giving rise to the obove couse (A) stoting the UNDERLYING CONDITION lost.	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Aortic insufficiency	Years

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		yes	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 9 19 65 to May 10 19 65, that (I)/(we) last saw the deceased alive on May 10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
James H. Frank,					5/10/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
James H. Frank, Surgeon (R)		US PHS Hospital, Balto, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/12/65	Balto. Nat. Cem.	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 12 1965	Robert E. Farley, M.D.	Schimunek Funeral Home, Inc. 3331 Brehms Lane

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

RGB

V-6221

BIRTH NO. 65 5028

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5028

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): BERTHA JIRECEK

2. DATE AND HOUR OF DEATH: MAY 10, 1965 — 7:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL WILKENS & CATON AVE. BALTO. MD.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 25-05
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1616 CHERRY STREET

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	WHITE	MARRIED	9-25-98	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	-------	POLAND	

13. FATHER'S NAME: —

14. MOTHER'S MAIDEN NAME: —

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
NO	217-14-1311	Charles JIRECEK 1616 Cherry St. ST. AGNES RECORDS, WILKENS & CATON AVE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

DUE TO (B)

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		YES	YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from MAY 8 1965 to MAY 10 1965, that (I) (we) last saw the deceased alive on MAY 10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: William Allan Dear M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 5-10-65

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS: ST. AGNES HOSPITAL, WILKENS & CATON AVE.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-14-65	Holy Cross	A.A. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR / ADDRESS
MAY 12 1965	Robert E. Faherty	Wm. S. Trialtowski 2007 Easter Ave

VS 150-REV. 1/1/65

43-50-03 IB1 - Released by Medical Examiner on Approval per Dr. Kho 5-550

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5029 — Registered No. 65 5029

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): John P. Simon, Sr.

2. DATE AND HOUR OF DEATH: 5-9-65 — 3:30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): RURAL
D. STREET ADDRESS (If rural, give location): 25 Flagship Road #21222

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Widowed	10-29-92	72				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman		Maryland	U. S. A.

13. FATHER'S NAME: Phillip Simon

14. MOTHER'S MAIDEN NAME: Justina Weber

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		215-03-4590	RECORDS-BCH-4940 Eastern Avenue #21224	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Burns 2° - 3° 55% — DUE TO: Thermal — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO:

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Cancer of Prostate — 6 months

CHIEF OR ASST. MEDICAL EXAMINER. CERTIFICATION APPROVED BY M.D.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0	X	No	

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Home	25 Flagship Road - Baltimore = #21222

21D. TIME OF INJURY (APPROX.) (Month)	(Day)	(Year)	(Hour)	21E. INJURY OCCURRED: While At Work ☐	Not While At Work ☒	21F. HOW DID INJURY OCCUR?
5	6	65	PM			Pajama top caught fire

22. I certify that (I) (this hospital) attended the deceased from 5-6 19 65 to 5-9 19 65, that (I) (we) last saw the deceased alive on 5-9 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Richard A. Lane M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ — 23B. DATE SIGNED: 5-9-65

23C. PHYSICIAN'S NAME (Type): Dr. Richard A. Lane M.D. — 23D. ADDRESS: BCH-4940 Eastern Avenue - #21224

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	May 12, 1965	Lorraine Pk. Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 12 1965	Robert E. Farley M.D.	Eugenia K. Seitz Seitz Funeral Home	5209 York Rd Baltimore, Maryland

VS 150-REV. 1/1/65

B-657 1

BIRTH NO. 65 5030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5030

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Ella Maude Barnes

2. DATE AND HOUR OF DEATH: 5—10—65 2 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Union Memorial Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 13-7
D. STREET ADDRESS (If rural, give location): Roland View Towers

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	W	1/18/90	75				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	—	Baltimore	USA

13. FATHER'S NAME: JAMES JACKSON

14. MOTHER'S MAIDEN NAME: LAURA WARMSLEY.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: MARGARET JACKSON ADDRESS 4416 NEWPORT AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

420.1 I

(A) Arteriosclerotic heart disease with narrowing of both coronary artery ostial.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

DUE TO (B) Hypertrophy of the left ventricle.

DUE TO (C) Generalized arteriosclerosis, marked.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Terminal aspiration of gastric content. Chronic congestion of liver & spleen.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5 - 9 - 1965 to 5 - 10 - 1965, that (I) (we) last saw the deceased alive on 5-10 — 1965 and that in(my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Miriam R. Cohen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 5-10-65

23C. PHYSICIAN'S NAME (Type): MIRIAM R. COHEN M.D.

23D. ADDRESS: UNION MEMORIAL HOSP. BALTO MD.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/13/65	St. Mary's, Hampden	3900 Roland Ave Balto Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 12 1965	Robert E. Farley M.D.	Austin E. Noonan	3815 Roland Ave

VS 150-REV. 1/1/65

C-450 1

BIRTH NO. 65-11698 65 5031

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5031

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Baby Girl Callahan

2. DATE AND HOUR OF DEATH: 5/10/65 — 11.20 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lutheran Hospital of Maryland.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 13-05
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 925 W 33rd ST.

5. SEX	6. RACE	7. ~~MARRIED~~, NEVER MARRIED ~~WIDOWED~~, ~~DIVORCED~~ (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	S	5/7/65			3	15	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE	—	Maryland.	U.S.A

13. FATHER'S NAME: ROBERT E. CALLAHAN

14. MOTHER'S MAIDEN NAME: HELEN E. GORDON.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — ADDRESS: ROBERT CALLAHAN - 925 W 33rd ST.

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: Cerebro-spinal Hemmorrhage

(B) DUE TO: Septicemia

(C): prematurity

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED — While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/7 19 65 to 5/10 19 65, that (I) (we) last saw the deceased alive on 5/10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Hosseim Golpira M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ — 23B. DATE SIGNED: 5/10/65

23C. PHYSICIAN'S NAME (Type): HOSSEIM GOLPIRA M.D. — 23D. ADDRESS: Preston St. Lutheran Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/12/65	Woodlawn	Woodlawn, Md.

25A. DATE REC'D BY HEALTH DEPT.: MAY 12 1965 — 25B. NAME OF REGISTRAR: Robt E. Fader, M.D. — 25C. FUNERAL DIRECTOR — ADDRESS: Chester E. Donovan - 3818 Pleasant Ave

VS 150-REV. 1/1/65

M- 1601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5032 Registered No. 65 5032

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): CATHERINE E. MOWBRAY

2. DATE AND HOUR OF DEATH: 5-11-65 | 12:15 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — CERTIFICATE CORRECTED 5-13-65
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 26-44
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 103 N. HIGHLAND AVE.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	M	12-20-32	32		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	—	MARYLAND	USA.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
ROBERT E. NOONAN	MARIE H. KOESTER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		PATIENT	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

I 410X
(A) PHONATIC HEART DISEASE — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) & MITRAL INSUFFICIENCY & CONGESTIVE FAILURE.
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
5-6-65	MITRAL INSUFFICIENCY		

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ____ 19 ____ to ____ 19 ____, that (I) (we) last saw the deceased alive on 5-11 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
N. W. Todd Jr.					5-11-65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
NEVINS W. TODD, JR. M.D.	UNIVERSITY HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5 14 65	Holy Cross Cemetery National	Brooklyn, A.A. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 12 1965	Robert E. Faber, M.D.	Mc Cully	130 E. Fort Ave

VS 150-REV. 1/1/65

W-300 1

BIRTH NO. 65 5033

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5033

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Robert White

2. DATE AND HOUR OF DEATH: 6/7/65 | 10 25 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 37 Mercy.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 4-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore.
D. STREET ADDRESS (If rural, give location): 2 N. Gay Street.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
m	w	married	2/22/02	63				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RESTARANT		Ohio	

13. FATHER'S NAME: FRANK ZUCKERMAN

14. MOTHER'S MAIDEN NAME: SOPHIA WHITE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	167-12-2118	RUBY WHITE	2 N GAY ST.

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not meon the mode of dying, e.g., heart foilure, osthenio, etc. It meons the diseose, injury or complicotion which coused deoth.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if ony, giving rise to the above couse (A) stoting the UNDERLYING CONDITION lost.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I 420.1
(A) DUE TO: Myocardial Infarction
(B) DUE TO: Arteriosclerotic C-V Dis.
(C): Diabetes Mellitus

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Uremia

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or obout home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Boltimore City, give exoct locotion)

21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify thot (I) (this hospitol) ottended the deceased from April 2 1965 to May 30 1965, thot (I) (we) lost saw the deceosed olive on April 30 1965 ond that in (my) (our) opinion deoth occurred on the dote ond hour ond from the couses stoted above. (I) (We) (did) (did not) view the body after deoth.

23A. SIGNATURE: Stuart K. Hurley M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 5/7/65

23C. PHYSICIAN'S NAME (Type): M.D.

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5-11-65	Mt CARMEL	BALTIMORE Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 12 1965	R. C. & E. Fahrney M.D.	Jack Lewis Inc 2100 Eutaw Pl

VS 150-REV. 1/1/65

F321 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5034 Registered No. 65 5034

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BERNADINE C. FITZPATRICK

2. DATE AND HOUR OF DEATH: May 10, 1965 | 7.40 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceosed lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 8-06
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21213
D. STREET ADDRESS (If rurol, give locotion): 1519 N. Wolfe St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In yeors lost birthday)	If Under 1 Yr. Months / Doys	If Under 24 Hrs. Hours / Min.
Female	White	Never married	June6.1897	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Secty. U.S. Govt.		Baltimore Md.	USA

13. FATHER'S NAME: Bernard Fitzpatrick

14. MOTHER'S MAIDEN NAME: Mary E. Kierley

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		George R. Nake, Attorney	1111 Court Sq. Bldg. Baltimore 21202

MEDICAL CERTIFICATION

1B. 422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO	Arteriosclerotic Cardiovascular Disease	
(B) DUE TO	Malnutrition	
(C)	Intra abdominal mass.	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		no	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exoct locotion)

21D. TIME OF INJURY (APPRDX.) (Month) (Doy) (Yeor) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify thot (I) (this hospitol) ottended the deceosed from 5 - 7 - 1965 to 5 - 10 - 1965, thot (I) (we) lost sow the deceosed olive on 5 - 10 1965 ond thot in (my) (our) opinion deoth occurred on the dote ond hour ond from the couses stoted obove. (I) (We) (did) (did not) view the body ofter deoth.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
Donald M. Wood		☐	☐	☑	5/12/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
DONALD M. WOOD		South Baltimore General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	May 14.1965	New Cathedral Cemetery	Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 12 1965	Robert E. Farley M.D.	HENRY SANDER & SONS. INC. Baltimore Md.

VS 150-REV. 1/1/65

J6351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5035 Registered No. 65 5035

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Oliver P. Jordan

2. DATE AND HOUR OF DEATH: MAY 10, 1965 4:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 8-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2404 E. NORTH AVENUE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
MALE	WHITE	WIDOWER	2-10-94	71				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CARPENTER RETIRED		BALTIMORE MARYLAND	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
OLIVER P. JORDAN	MARY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	219 05 0739	Mrs Mildred Murray	1808 Redwood Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
1B. 334X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) DUE TO: Septicemia	24 hr
	(B) DUE TO: Pneumonia	1 wk
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(C): Stroke	1 wk
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Urinary tract infection	unknown

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
—	—	yes	No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	—	—

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?
—		—

22. I certify that ~~I~~ (this hospital) attended the deceased from 5/6/1965 to 5/10/1965, that ~~I~~ (we) last saw the deceased alive on 5/10/1965 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~I~~ (We) ~~did~~ ~~did not~~ view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
Kenneth E. Quickel Jr.					5/10/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
KENNETH E. QUICKEL JR. M.D.	Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/13/65	PARKWOOD CEMETERY	BALTIMORE MARYLAND

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 12 1965	Robert E. Farley M.D.	HENRY SANDER & SONS INC. BALTIMORE MARYLAND

VS 150-REV. 1/1/65

JHH #65 08 31

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-530 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 6503726 | Registered No. 65 5036

M.E. CASE NO. 65 5036

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): ANTHONY GREGORY SMITH

2. DATE AND HOUR OF DEATH: 4/20/65 | 2.10 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): SINAI HOSPITAL Belvedere Ave at Greenspring. BALTIMORE, MD.

4. USUAL RESIDENCE (Where deceosod lived. If institution: residenco before admission)
A. STATE: SINAI HOSPITAL B. COUNTY: 27-17
C. CITY OR TOWN (If outsido city limits, write RURAL ond give township): BALTIMORE MD
D. STREET ADDRESS (If rurol, give locotion): Belvedere Ave. at Greenspring.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In yeors lost birthdoy)	If Under 1 Yr. Months	Doys	If Under 24 Hrs. Hours	Min.
M	N	SINGLE	2-15-65	65 DAYS	2			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE	NONE	BALTIMORE MD	U.S

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME: ANGELA SMITH.

15. Wos Decoosed Ever in U. S. Armed Forces? (Yes, no or unknown) (If yos, give wor or dotos of sorvice)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO			1919 N. CASTLE ST #23

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heort foilure, osthenia, etc. It means the disease, injury or complication which caused deoth.)

(A) Chronic Renal Failure. — INTERVAL BETWEEN ONSET AND DEATH: 30 DAYS

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the obove cause (A) stating the UNDERLYING CONDITION lost.

(B) DUE TO: Respiratory arrest

(C): Primary Renal Disease.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		✓	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol oxominor)	21B. PLACE OF INJURY (e.g., in or about home, form, foctory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exoct locotion)

21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospitol) attended the deceased from 2-15-65 19 65 to 4/20/65 19 65, that (I) (we) lost saw the deceased alive on 4-20 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: R Rodriguez M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐ — 23B. DATE SIGNED: 4/20/65

23C. PHYSICIAN'S NAME (Type): ROMEO. S RODRIGUEZ M.D. — 23D. ADDRESS: SINAI HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE: MAY 10 1965 | 24C. NAME of CEMETERY or CREMATORY: ANATOMY BOARD OF MARYLAND | 24D. LOCATION (City, town, or county) (State): UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD

25A. DATE REC'D BY HEALTH DEPT.: MAY 12 1965 | 25B. NAME OF REGISTRAR: Robert E. Faber, M.D. | 25C. FUNERAL DIRECTOR | ADDRESS

VS 150-REV. 1/1/65

F-250 1

BIRTH NO. 65-08766 65 5037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5037

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) FAGAN BABY BOY

2. DATE AND HOUR OF DEATH 4/4/65 12 40 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSP OF BALTIMORE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY 2003
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 2021 Fredrick Ave. (23)

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W		4/3/65			1	16	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	—	MARYLAND	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
NONE LISTED	ELIZABETH FAGAN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—	—	

MEDICAL CERTIFICATION

18. 776 X 1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) PREMATURITY — INTERVAL BETWEEN ONSET AND DEATH: 40 HRS

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
—		✓	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-3 1965 to 4-5 1965, that (I) (we) last saw the deceased alive on 4-5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
Sherman Su Chang					4/5/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
SHERMAN S. CHANG		SINAI HOSP OF BALTIMORE

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, Town, or County) (State)
	MAY 10 1965		ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 12 1965	C. L. & E. Fisher, M.D.	MORTUARY SERVICE - BCHD

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-620 1

BIRTH NO. 65-10938 65 5038

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 5038

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Baby of [illegible]ce Morris
2. DATE AND HOUR OF DEATH: May 4, 1965 | 8:55 p. m.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND
   FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): Provident Hospital, 1514 Division Street, Baltimore, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
   A. STATE: Maryland
   B. COUNTY: 15-02
   C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
   D. STREET ADDRESS (If rural, give location): 1717 Monroe Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Negro	Single	5-3-65				18	17

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	USA

13. FATHER'S NAME: Nathaniel Morris
14. MOTHER'S MAIDEN NAME: Joyce McCready

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not meon the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Respiratory distress Syndrom

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO: Immaturity

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospitol) attended the deceased from May 3, 1965 19 to May 4, 1965 19, that (I) (we) last saw the deceased alive on May 4, 1965 19 and thot in (my) (our) opinion deoth occurred on the dote and hour and from the couses stoted above. (I) (We) (did) (did not) view the body after deoth.

23A. SIGNATURE: M. Behrooz M.D. Attending Phys. ☐ Med. Director ☐ Stoll Phys. ☒

23B. DATE SIGNED: May 6, 1965

23C. PHYSICIAN'S NAME (Type): Manootchehr Behrooz M.D.

23D. ADDRESS: 1514 Division Street

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE: MAY 10 1965

24C. NAME of CEMETERY or CREMATORY: ANATOMY BOARD OF MARYLAND

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.: MAY 12 1965

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD

ADDRESS

VS 150-REV. 1/1/65

P-625 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.
M.E. CASE NO. 65 5039

Registered No. 65 5039

1. NAME OF DECEASED (Type or Print): Marvin Perkinson

2. DATE AND HOUR OF DEATH: 5-10-1965 7.15A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residenco bofore odmission)
A. STATE: Maryland
B. COUNTY: 9-01
C. CITY OR TOWN (If outsido city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rurol, give locotion): 4120 The Alameda 21218

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Widowed	7-3-1881	83				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Superintendent	Spedden Shipbuilding	Virginia	U.S.A.

13. FATHER'S NAME: Lehay Perkinson

14. MOTHER'S MAIDEN NAME: Elizabeth Britton

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	217-03-0150	Records	4940 Eastern Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	INTERVAL BETWEEN ONSET AND DEATH
I (A)	Arterio Sclerotic Cerebral Vascular Disease	7 years
DUE TO (B)	Epilepsy	7 years
DUE TO (C)		

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-23- 19 65 to 5-10- 19 65, that (I) (we) last saw the deceased alive on 5-10- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
Philip Zieve					5-10-1965

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Dr. Philip Zieve		4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/13/65	New Cathedral Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 12 1965	Robert E. Faber M.D.	John A. Moran	3000 E. Baltimore St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-524 1

DR. LOCK LMD TO SIGNRELEASED AS NON MED BY DR CENDA NA ME.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5040 — Registered No. 65 5040

1. NAME OF DECEASED (Type or Print): ENGLES, FRANCIS
2. DATE AND HOUR OF DEATH: 5/11/65 — 7:40 am M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND
   FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Johns Hopkins Hospital
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
   A. STATE: Md — B. COUNTY: 7-01
   C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
   D. STREET ADDRESS (If rural, give location): 622 N. Curley St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	married	11/27/98	66				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Wm. H. Cole & Sons	Baltimore, Maryland	USA

13. FATHER'S NAME: SAMUEL Engles
14. MOTHER'S MAIDEN NAME: ~~MARY RUKEL~~ MARY Ruckel

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	213-03-5674A	Mrs. Mary F. Engles 622 N. Curley St

MEDICAL CERTIFICATION

18. 420.1 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	myocardial infarction	5 min
DUE TO (B)	Chronic congestive heart failure	1 month ?
DUE TO (C)	coronary insufficiency	2-3 months ?

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from Jan 1956 to May 8 1965, that (I) (we) last saw the deceased alive on May 8 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☒	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
Burton V. Lock MD					5/12/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
BURTON V. LOCK		2936 E. Balto St Balto 24 Md

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/14/65	Oak Lawn Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 12 1965	Robert E. Farley M.D.	John A. Moran, Inc. 3000 E. Balto. St

VS 150-REV. 1/1/65

A-625 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5041 — Registered No. 65 5041

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): PAUL ARGENTO
2. DATE AND HOUR OF DEATH: 5/11/65 — 6:00 P M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Sq. Hosp. 36
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY: 27-10
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12
D. STREET ADDRESS (If rural, give location): 504 East 23rd St.
5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 5/4/1891
9. AGE (In years last birthday): 73
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Store Clerk
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Anthony Argento
14. MOTHER'S MAIDEN NAME: Catherine Lovecamo
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 214-38-3764
17. INFORMANT: Mamie Rebstock — ADDRESS:

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) — CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

203X I

(A) Chronic blood loss — 3 weeks

DUE TO

(B) Multiple myeloma — 2 yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED — While At Work ☐ — Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/4/65 19 to 5/11/65 19, that (I) (we) last saw the deceased alive on 5/11/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: S. Munoses — M.D. — Attending Phys. ☐ — Med. Director ☐ — Staff Phys. ☑
23B. DATE SIGNED: 5/11/65
23C. PHYSICIAN'S NAME (Type): Silvino B. Munoses — M.D.
23D. ADDRESS: 101 Calhoun St. Balto. Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 5/15/65
24C. NAME of CEMETERY or CREMATORY: Woodlawn Cemetery
24D. LOCATION (City, town, or county) (State): Balto. Md

25A. DATE REC'D BY HEALTH DEPT.: MAY 12 1965
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Thos. G. Morgan Inc. — ADDRESS: Spri & Pres. G. Gorman Jr.

VS 150-REV. 1/1/65

1

65-10672

B-420

BIRTH NO. 65 5042

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5042

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MICHELE BLAKE	2. DATE AND HOUR PRONOUNCED DEAD: 5-10-65 6:40 AM
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): PROVIDENT HOSPITAL - DOA	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-02 D. STREET ADDRESS (If rural, give location): 1302 Division Street - 21217

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.
Female	Colored	Single	April 26, 1965		2 weeks

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
infant		Balto. Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Milton Blake	Gloria Blake

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — ADDRESS
No		Gloria Blake 1302 Division St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

763.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bilateral pneumonitis

DUE TO

ANTECENDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: P W Rieckert M.D.

EXAMINER'S NAME (Type): PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED: 5-10-65

23A. BURIAL, CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME OF CEMETERY OR CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/13/65	Mt Auburn Cem.	Balto. Md.

24A. DATE RECD BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR — ADDRESS
MAY 12 1965	Robert E. Farber M.D.	Williams Funeral Home 3[illegible] Lafayette St

VS 151-REV. 1/1/65

2-5251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.
M.E. CASE NO. 65 5043

Registered No. 65 5043

1. NAME OF DECEASED (Type or Print): JOHNSON, GEORGE G.

2. DATE AND HOUR OF DEATH: 5/10/65 | 12 45 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lutheran Hospital of Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 16-06
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore.
D. STREET ADDRESS (If rural, give location): 2715 W. Lafayette Ave.

5. SEX: male
6. RACE: Color.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 11/5/93
9. AGE (In years last birthday): 71 years
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Porter - retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Arthur Johnson
14. MOTHER'S MAIDEN NAME: Julia ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): W.W. I
16. SOCIAL SECURITY NO.: 216-10-4370
17. INFORMANT: Raymond Johnson. ADDRESS: 2715 W. Lafayette Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) upper gastero intestinal bleeding unknown Etiology.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

DUE TO (B)

DUE TO (C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/9/1965 to 5/10/1965, that (I) (we) last saw the deceased alive on 12 40 PM. 5/10/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: S. Rafaice, M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 5/10/65.
23C. PHYSICIAN'S NAME (Type):
23D. ADDRESS: Lutheran Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 5/14/1965
24C. NAME of CEMETERY or CREMATORY: Balto. National Cem
24D. LOCATION (City, town, or county) (State): Balto. Md

25A. DATE REC'D BY HEALTH DEPT.: MAY 12 1965
25B. NAME OF REGISTRAR: Robert E. Faber M.D.
25C. FUNERAL DIRECTOR ADDRESS: Williams Funeral Home 319 N. Schroeder St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

#-500 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5044 Registered No. 65 5044

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): MARY ELLEN HANEY (Miss)

2. DATE AND HOUR OF DEATH: 5-11-65 (5/11/65) 12:55 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location)
JENKINS MEMORIAL HOSPITAL
1000 S.Caton Ave.
Baltimore, Md. 21229

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 27-10
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, Md.
D. STREET ADDRESS (If rural, give location): 5106 Midwood Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	Never married	5-21-1888	76				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Food Checker	Emerson Hotel	Baltimore, Md	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Patrick Haney	Ellen Welsh

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		070-09-1726	A-	Medical Records Rm

MEDICAL CERTIFICATION

18. 420.01

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Pneumonia	2 weeks
DUE TO (B)	Cachexia	months
DUE TO (C)	Chronic brain syndrome	1 year
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Arteriosclerotic heart disease	5 yrs

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from 5/11 1962 to 5/11 1965, that (I) (we) last saw the deceased alive on 5/11 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
J Raymond Gladue M.D.	Attending Phys. ☐ Med. Director ☒ Staff Phys. ☐	5/11/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
J.Raymond Gladue M.D.	3350 Wilkens Ave.21229

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/14/1965	New Cathedral Cem.	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 12 1965	Robert E. Fahey M.D.	H.W.Jenkins & Sons Co. 4905 York Road Baltimore 12, Md.

VS 150-REV. 1/1/65

E-152 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5045 Registered No. 65 5045

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ROBERT EARL EVANS

2. DATE AND HOUR OF DEATH: 5/12/65 | 8:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD B. COUNTY: 9-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALT.
D. STREET ADDRESS (If rural, give location): 4008 WILSBY AVE.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	MARRIED	7/27/92	72				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
BUILDING CONTRACTOR	BUILDING	MD	U.S.A.

13. FATHER'S NAME: JOHN EVANS

14. MOTHER'S MAIDEN NAME: MARY ELIZABETH BEAN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): ~~Unk~~ NO

16. SOCIAL SECURITY NO.: 577-05-3787

17. INFORMANT: UMH CHART ADDRESS: CITY

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 443X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) SUBARACHNOID HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 5 DAYS

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

DUE TO (B) HYPERTENSIVE CARDIOVASCULAR DISEASE — 5 YEARS

DUE TO (C) IDIOPATHIC HYPERTENSION — >5 YR

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
—	—	NO	—

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	—	—

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ — Not While At Work ☐	21F. HOW DID INJURY OCCUR?
—		—

22. I certify that (I) (this hospital) attended the deceased from 5/8/1965 to 5/12/1965, that (I) (we) last saw the deceased alive on 5/12/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: A. Laird Bryson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED: 5/12/65

23C. PHYSICIAN'S NAME (Type): A. LAIRD BRYSON M.D. 23D. ADDRESS: UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-15-65	New Cathedral	Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 12 1965	Robert E. Fabian M.D.	H.W. Jenkins & Sons Co. 4905 York Rd.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-452 1

BIRTH NO. 65 5046

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5046

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): ROLNICK, MARY F. (ROLNIAK)

2. DATE AND HOUR OF DEATH: May 9, 1965 | 8:20 a. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): St. Joseph Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 105
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2107 Bank Street #31

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Married	11-1-1908	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frank Kaczorowski	Frances Wazienioska

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	217-07-6437	Cecilia los	2120 Bank St.

MEDICAL CERTIFICATION

18. 571.01

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) ~~Due to~~ Portal cirrhosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(B) ~~Due to~~ Cerebro-vascular accident probably thrombosis.
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 8, 1965 to May 9, 1965, that (I) (we) last saw the deceased alive on May 9, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Hector C Mendez M.D. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: May 9, 1965

23C. PHYSICIAN'S NAME (Type): Hector C. Mendez, M.D.

23D. ADDRESS: 1400 N. Caroline Street, Balto., Md. 21213

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/13/65	Holy Rosary Cemetery	Baltimore, Co. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 12 1965	Robert E. Fabian, M.D.	John M. Weber & Sons Inc. 401 S. Chester St.

VS 150-REV. 1/1/65

K-3411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. 65 5047

M.E. CASE NO. 65 5047

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): IGNACY KADLUBOWSKI

2. DATE AND HOUR OF DEATH: MAY 9 1965 | 10.10 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 3218 O'DONNELL ST.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD B. COUNTY: 26-11
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 3218 O'DONNELL ST

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	MARRIED	7-29-1885	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CARPENTER		POLAND	

13. FATHER'S NAME: JOSEPH KADLUBOWSKI

14. MOTHER'S MAIDEN NAME: JOZEFA —

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		213-16-0494	MARY KADLUBOWSKI	3218 O'DONNELL ST

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 420.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Arteriosclerotic Gangrene both legs — INTERVAL BETWEEN ONSET AND DEATH: 1 mo.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO: arteriosclerotic Heart disease — ?

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from May 5 1965 to May 9 1965, that (I) (~~we~~) last saw the deceased alive on May 9 1965 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Louis F. Klixnes M.D. — Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: May 11, 1965

23C. PHYSICIAN'S NAME (Type): LOUIS F. KLIXNES M.D.

23D. ADDRESS: 2623 E. Monument St 5

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5-12-1965	HOLY CROSS NATIONAL CEM	GERMAN HILL RD

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 12 1965	Robert E. Farley M.D.	John M. Weber & Sons Inc	401 S. Chester St.

VS 150-REV. 1/1/65

1

N-400

BIRTH NO. 65 5048

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5048

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MINNIE NEAL	2. DATE AND HOUR PRONOUNCED DEAD: 5-10-65 | 9:30 A M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 1123 N. CAROLINE STREET	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-07 D. STREET ADDRESS (If rural, give location): 1123 N. Caroline Street -21213

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	Colored	Widow	11/13/09	55		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NURSES AID	Hosp-	VA.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
?	SUSIE JOHNSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	214-24-0837	EDWARD NEAL	785 GRANTLEY ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease — 422.1

DUE TO

ANTECENDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection XX Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes [X] Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER [X]

DATE SIGNED: 5-10-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
BURIAL	5/13/65	Mt. CALVARY	A.A. County Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 12 1965	R.L. & E. Farber M.D	Joseph B. Lochte Jr	1304 N. Central Ave

VS 151-REV. 1/1/65

2525 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5049 Registered No. 65 5049

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Wyatt Johnson

2. DATE AND HOUR OF DEATH: 5-10-65 | 1:30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 8-07
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rurol, give locotion): 1618 E. BIDDLE ST.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In yeors lost birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	NEGRO	MARRIED	1-12-05	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CHIPPER	Bethlehem Steel	VA.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOHN JOHNSON	RODIE EPPERSON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	217-01-3749	Edna Johnson	1618 E. Biddle St

MEDICAL CERTIFICATION

18. 3-26X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which coused death.)

CAUSE OF DEATH

(A) DUE TO: Chronic renal failure — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

(B) DUE TO: Retroperitoneal fibrosis — 4 yrs.

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
April 1962	Retroperitoneal fibrosis	yes	No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?
—	—	—

22. I certify that ~~I~~ (this hospital) attended the deceased from 4/29/1965 to 5/10/1965, that ~~I~~ (we) last saw the deceased alive on 5/10/1965 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
Kenneth E. Quickel Jr.					5/10/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
KENNETH E. ~~Q+o~~ QUICKEL, JR. M.D.	Johns Hopkins Hospital, Balto. Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/14/65	Arbutus Mem. Pk	Arbutus, Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 12 1965	Robert E. Faiby, M.D.	Joseph D. Locke Jr.	1304 N. Carey St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. B 650 65 5050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5050

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOSEPHINE HOOPER (BURTON)

2. DATE AND HOUR OF DEATH: 5-11-65 | 5:50 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 8-05
D. STREET ADDRESS (If rural, give location): 2017 E. NORTH AVENUE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	NEGRO	WIDOW	11-14-93	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Maid	Hospital	Md.	

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: MARY CAMPHOR

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	214-30-3426	Martha Burns	2017 E. North Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) DUE TO: Diffuse Metastatic Carcinoma Colon	1 yr.
ANTECEDENT CAUSES: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(B) DUE TO:	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-30 19 65 to 5-11 19 65, that (I) (we) last saw the deceased alive on 5-11 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
Bruce Lee Evatt M.D.	Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑	5-11-65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
BRUCE LEE EVATT M.D.	Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/15/65	Mt. Calvary	A. A. County, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 12 1965	Robert E. Farley, M.D.	Joseph G. Locks, Jr.	1304 N. Central Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-355 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

BIRTH NO. 65 5051 Registered No. 65 5051

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARGARET H. PITTMAN

2. DATE AND HOUR OF DEATH: 5/10/65 3:30 p.m. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND (If not in hospital or institution, give street address or location)
CERTIFICATE CORRECTED 5-27-65
HOSPITAL OR INSTITUTION: LUTHERAN HOSPITAL BALTO. 16, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township): ~~BALTIMORE~~ CATONSVILLE. 5300
D. STREET ADDRESS (If rural, give location): 6231 Gilston Park Rd # 28

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	Widowed.	10-25-~~97~~ 1898	~~Age~~ 66				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Domestic	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Howard Dietz	Rose Blumberg

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	NONE	213-10-1456	B. Mrs. Tissl	6231 Gilston Park Rd

MEDICAL CERTIFICATION

18. I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Generalized Peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 8 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO: Perforation Sigmoid Diverticulum

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No.	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from May 2 1965 to May 10 1965, that (I) (we) last saw the deceased alive on 3:30 pm May 10, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
Angel H. Roque		☐	☐	☑	5/10/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
ANGEL H. ROQUE M.D.	LUTHERAN HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5-13-65	WESTERN	BALTIMORE, Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 12 1965	Robert E. Farley M.D.	C.E.L. Schurb Funeral Home Francis H. Miller 2101 Frederick Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Birth Cert. A-96288 - 10-25-1898
5-27-65 M.H.

1

B-525

BALTIMORE CITY HEALTH DEPARTMENT

65 5052

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 65 5052 Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ROBERT W. BENSON	2. DATE AND HOUR PRONOUNCED DEAD 5-10-65 | 10:00 A M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4907 CHALLEDON ROAD	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 28-03 D. STREET ADDRESS (If rural, give location) 4907 Challedon Road - 21207

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months / Days / Hours / Min.
Male	White	Married	9/28/41	23	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Social Security	Phila. Pa.	U.S.A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Wayne R. Benson	Edith Burgess

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	Army		Wayne R. Benson-	223 W. County Line Hatboro, Penna.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute laryngeal edema

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Peter W. Rieckert M.D.

EXAMINER'S NAME (Type) PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED 5-10-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/14/65	Hillside Cemetery	Roslyn, Penna.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 12 1965	Robert E. Fahey M.D.	Loring Byers	8728 Liberty Rd. Randallstown Md. 21133

VS 151-REV. 1/1/65

M-216 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5053 Registered No. 65 5053

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): MC FARLAND JOHN J.

2. DATE AND HOUR OF DEATH: 5/10/65 | 1.30 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Md. General Hospital Baltimore Md

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): HYDES 53-00
D. STREET ADDRESS (If rural, give location): Box 88 Rt 1

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	M	5/13/93	71				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SEC.		MARYLAND	U.S.A

13. FATHER'S NAME: E. DODD Mc FARLAND

14. MOTHER'S MAIDEN NAME: CLARA SACHS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 216-14-7427

17. INFORMANT: MARYLAND GEN. HOSP. ADDRESS: 827 LINDEN AVE

CAUSE OF DEATH

18. 465 X 1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO: PULMONARY INFARCTION.

(C):

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/9 19 65 to 5/10 19 65, that (I) (we) last saw the deceased alive on 5/10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Pietro Lastrucci M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ — 23B. DATE SIGNED: 5/10/65

23C. PHYSICIAN'S NAME (Type): LASTRUCCI PIETRO M.D. — 23D. ADDRESS: MARYLAND GEN. HOSP.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	May 12 1965	Gardens of Faith	Kenwood Balto	Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 12 1965	Robert E. Farley M.D.	A.H. Archer	Benson Md

VS 150-REV. 1/1/65

W-2301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5054 Registered No. 65 5054

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): James W West

2. DATE AND HOUR OF DEATH: May 9, 1965 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION: (If not in hospitol or institution, give street oddress or location) 3604 - 3rd St Baltimore 25, Md

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY: 3604 - 3rd St. Baltimore 25 Md
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 25-04

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	W	Married	9/7/84	80				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Super Clin Math	Chemical	N C	USA

13. FATHER'S NAME: Henry West

14. MOTHER'S MAIDEN NAME: Harriet Waddel

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	Span Amer		Family	

MEDICAL CERTIFICATION

18. 172X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the diseose, injury or complication which coused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the obove couse (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Carcinoma of the prostate with metastesis to lungs
DUE TO

(B) Duodenal ulcer
DUE TO

(C) Arteriosclerotic heart disease

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from January 1959 to May 9 1965, that (I) (we) last saw the deceased alive on May 9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Samuel Rubin M.D. — Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐ — 23B. DATE SIGNED: 5/20/65

23C. PHYSICIAN'S NAME (Type): Samuel Rubin, M.D. M.D.

23D. ADDRESS: 203 Patapsco Avenue Baltimore, Md. 21225

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/14/65	Hollywood Cem	Gastonia, N.C.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 12 1965	Robert E. Fahrney	McCully F H	237 Patapsco Ave 25

VS 150-REV. 1/1/65

M-254 1

St. Mary's Co. Md.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

BIRTH NO. 65 5055 Registered No. 65 5055

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOHN E. MCNEAL

2. DATE AND HOUR OF DEATH: 5/8/65 | 8 50 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: (ST. MARYS)
C. CITY OR TOWN (If outside city limits, write RURAL and give township): PINEY POINT
D. STREET ADDRESS (If rural, give location): 68-00 BAY VIEW

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
WHITE	MALE	NEVER MARRIED	5-6-65			3		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JOSEPH C. MCNEAL

14. MOTHER'S MAIDEN NAME: SANDRA B. VALLANDINGHAM.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Joseph C. McNeal	Piney Point, Maryland

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 75-1.6 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) DUE TO: Pulmonary Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(B) DUE TO:
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: prematurity, meningomyelocele

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
#5/7/65	meningomyelocele	YES.	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 7 1965 to May 8 1965, that (I) (we) last saw the deceased alive on May 8 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Peter Nissley M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐ House Staff — 23B. DATE SIGNED: May 8, 1965

23C. PHYSICIAN'S NAME (Type): Peter Nissley M.D. — 23D. ADDRESS: Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/10/65	St. George Cemetery	Valley Lee, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 12 1965	Robert E. Farley M.D.	W. Clarke Mattingley Leonardtown, Maryland

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-155 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5056 Registered No. 65 5056

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Joseph ~~J~~ Kaufman ~~Kaufman~~

2. DATE AND HOUR OF DEATH: 5-11-65 | 1 20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rurol, give locotion): 6513 Harford Road

5. SEX: M | 6. RACE: Cauc | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed | 8. DATE OF BIRTH: 1-23-1888 | 9. AGE (In yeors lost birthdoy): 77 | If Under 1 Yr. Months Doys | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Emp. Gas & Elect. Co.
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John B. ~~Kaufman~~ Kaufman
14. MOTHER'S MAIDEN NAME: Gertrude Muth

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dotes of service): no
16. SOCIAL SECURITY NO.: 212053352
17. INFORMANT: Mrs Mary Seibert ADDRESS: same

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Intracerebral hemorrhage
DUE TO left hemisphere, extensive
(B) Arteriosclerosis generalized
DUE TO severe of cerebral arteries
(C) ARB

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-2 19 65 to 5-11 19 65, that (I) (we) last saw the deceased alive on 5-11 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Rodney L. Brimhall M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 5-11-65
23C. PHYSICIAN'S NAME (Type):
23D. ADDRESS: Union Memorial Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): burial
24B. DATE: 5-15-65
24C. NAME of CEMETERY or CREMATORY: Gardens of Faith Cem.
24D. LOCATION (City, town, or County) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: MAY 12 1965
25B. NAME OF REGISTRAR: R. L. & E. Fe[illegible]
25C. FUNERAL DIRECTOR ADDRESS: Leonard J. Ruck Inc Baltimore, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-3241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5057 Registered No. 65 5057

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Martin John Stickler

2. DATE AND HOUR OF DEATH: May 10th, 1965 | 11:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location): Gould Convalesarium 6116 Belair Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 26-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rurol, give location): 4203 White Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
male	white	widowed	2-19-1872	93				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Clothing designer		Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jacob Stickler	Agnes

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	214019066	Gerard T. Stickler	30341/2 Pinewood Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
1B. 4221 I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not meon the mode of dying, e.g., heort foilure, osthenio, etc. It meons the diseose, injury or complicotion which coused deoth.)	(A) Senility	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if ony, giving rise to the above couse (A) stoting the UNDERLYING CONDITION lost.	(B) DUE TO Generalized Arteriosclerosis	20 yrs
	(C) DUE TO Myocardial Infarction	4 days
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exoct location)

21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this haspital) attended the deceased from Oct 7 19 64 to May 10 19 65, that (I) (we) last saw the deceased alive on May 10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stoted obave. (I) (We) (did) (did nat) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
David Miller					5/12/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Daniel Miller		4321 Stanford Road

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	5-14-65	Holy Redeemer Cem.	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 12 1965	R. Lee Fahey M.D.	Leonard J. Ruck Inc Baltimore, Md.

VS 150-REV. 1/1/65

A-536 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5058 Registered No. 65 5058

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Julius A. Anderson, Sr.

2. DATE AND HOUR OF DEATH: May 11, 1965 | 9:15 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2811 Erdman Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 8-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2811 Erdman Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
male	white	married	Jan. 6, 1899	66				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Printer		Baltimore, Maryland	U.S.A.

13. FATHER'S NAME: Richard Anderson

14. MOTHER'S MAIDEN NAME: Emma King

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs. Matilda Anderson	2811 Erdman Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

I (A) Emphysema - DUE TO (B) DUE TO (C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH: 10 yr.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Congestive Cardio vascular disease — 1 yr.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
—	—	no	—

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
—	While At Work ☐ Not While At Work ☐	—

22. I certify that (I) (this hospital) attended the deceased from 2-22 1961 to 5-11 1965, that (I) (we) last saw the deceased alive on 5-10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J. Dover Moores M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐ 23B. DATE SIGNED: 5-12-65

23C. PHYSICIAN'S NAME (Type): J. DOVER MOORES M.D. 23D. ADDRESS: 3105 BELAIR RD. 21213

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	5-14-65	Parkwood Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 12 1965	Robert E. Farley M.D.	Leonard J. Ruck Inc	5305 Harford Road #14

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-550 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5059 Registered No. 65 5059

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Ellen, Nellie A. Schuman

2. DATE AND HOUR OF DEATH 5-10-65 1:35 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location) South Baltimore General Hosp. 1413 Hull St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 24-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore # 21230.
D. STREET ADDRESS (If rural, give location)

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F.	W.	Widow.	1-6-87	78.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Housewife.	Baltimore, Md.	U.S.A

13. FATHER'S NAME William Ferguson.

14. MOTHER'S MAIDEN NAME Bridget O'Hara.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	219-28-8748	Mrs Dolores Lechowicz	936 Blakistone Rd

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 422.1 I

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO Generalized ASCVD

(B) DUE TO AS HD

(C) Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No.	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from 4-24 19 65 to 5-10 19 65, that (we) last saw the deceased alive on 5-10 19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Mod. Director	Staff Phys.	23B. DATE SIGNED
M.W. Kilchenstein		☐	☐	☑	5-10-65.

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Dr. M. W. Kilchenstein		South Baltimore General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	10/15/65	New Cathedral Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 12 1965	Robert E. Farley, M.D.	Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-530 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5060 Registered No. 65 5060

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Herman W. Smith.

2. DATE AND HOUR OF DEATH: 5-7-65 | 12:20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): South Baltimore General Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 2-4-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #21230.
D. STREET ADDRESS (If rural, give location): 1409 Hull St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M.	W.	Widowed.	1-20	77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired.		Maryland	USA

13. FATHER'S NAME: William Smith

14. MOTHER'S MAIDEN NAME: Frome

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 218-18-5830

17. INFORMANT: Ruth Golowacki ADDRESS: 1409 Hull St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

I
(A) DUE TO: Acute Myocardial Infarction
(B) DUE TO: Hypertensive Arteriosclerotic Cardiovascular disease
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPRDX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that ~~I~~ (this hospital) attended the deceased from 5-7 19 65 to 5-7 19 65, that ~~I~~ (we) last saw the deceased alive on 5-7 19 65 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
Sigmund A. Amitin M.D.	Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑	5-7-65.

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Dr. Sigmund A. Amitin M.D.	South Baltimore General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	10/11/65	Holy Cross Cemetery	Anne Arundel, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 12 1965	R. L. & E. Farber M.D.	Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-252 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

BIRTH NO. M.E. CASE NO. 65 5061 — Registered No. 65 5061

1. NAME OF DECEASED (Type or Print): Likens, Josephine Pearl

2. DATE AND HOUR OF DEATH: May 10, 1965 — 9:45 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): St. Joseph Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY: Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Perry Hall 63-00
D. STREET ADDRESS (If rural, give location): 4245 Chapel Rd.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Widowed	April 28, 1886	79				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Homemaker		Baltimore Co., Maryland	

13. FATHER'S NAME: Ringgold Blunt

14. MOTHER'S MAIDEN NAME: - Linstead

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: John R. Likens-4245 Chapel Rd.

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) — CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cerebrovascular hemorrhage;
Arteriosclerotic cardiovascular disease with atrial fibrillation.
(B) DUE TO Diabetes mellitus.
(C) DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above couse (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

NOT A MEDICAL EXAMINER'S CASE — CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Home	4245 Chapel Rd., Perry Hall, Md.

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work X	21F. HOW DID INJURY OCCUR?
May 7, 1965		Fell out of bed

22. I certify that (I) (this hospital) attended the deceased from May 7, 1965 to May 10, 1965, that (I) (we) last saw the deceased alive on May 10, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Glocrito G. Sagisi M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. X — 23B. DATE SIGNED: May 10, 1965

23C. PHYSICIAN'S NAME (Type): Glocrito G. Sagisi, M.D. — 23D. ADDRESS: 1400 N. Caroline St., Baltimore, Md. 21213

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-13-65	Parkwood Cemetery	Balto Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR — ADDRESS
MAY 13 1965	Robert E. Farley, M.D.	John C. Miller Inc. - 6415 Belair Rd.

VS 150-REV. 1/1/65

RELEASED BY MEDICAL EXAMINER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



B- 4521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5062 Registered No. 65 5062

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FRIEDA BLANKMAN

2. DATE AND HOUR OF DEATH: MAY 10, 1965 4:15 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: R. Mont
C. CITY OR TOWN (If outside city limits, write RURAL and give township): HYATTSVILLE 66-00
D. STREET ADDRESS (If rural, give location): 5439 16TH AVENUE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
FEMALE	WHITE	SEPARATED	4/12/1912	53				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	AT HOME	BALTIMORE, MARYLAND	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JULIUS MILLER	HATTIE SHAMOWITZ

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO			MR. MEYER PRUCE	3742 CLARINTH RD

MEDICAL CERTIFICATION

18. 443X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cerebro-Vascular Accident — Sudden Death
DUE TO
(B) Arterio-sclerotic C.V.D. — 5 years.
DUE TO
(C) Hypertension — 3 years.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from 2/1 1962 to 5/10 1965, that (I) (we) last saw the deceased alive on 5/5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☒	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
A. A. Silver M.D.					5/11/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
DR. A. A. SILVER		TEMPLE GARDEN APARTMENTS

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
BURIAL	5/11/65	HEBREW YOUNG MENS	BALTIMORE	MARYLAND

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	Robert E. Farley M.D.	SOL LEVINSON & BROS. INC.	6010 REISTERSTOWN RD

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-3201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5063 Registered No. 65 5063

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Robert Rudo

2. DATE AND HOUR OF DEATH: 5-10-65 | 4:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): 42 Sinai Hospital of Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 27-19
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 3400 W. Rogers Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Widowed	1-1-92	73				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CUTTER	CLOTHING	BALTIMORE, MARYLAND	USA

13. FATHER'S NAME: ZELIG RUDO

14. MOTHER'S MAIDEN NAME: SARAH FRIEDMAN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		MRS. EVELYNNE MARGOLIS	3400 W ROGERS AVE

MEDICAL CERTIFICATION

18. 260X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Coronary Artery Disease	
DUE TO (B)	Arteriosclerotic Cardiovascular Disease	
DUE TO (C)	Diabetes Mellitus	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-4-1965 to 5-10 1965, that (I) (we) last saw the deceased alive on 5-10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Larry Rucker, M.D. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 5-10-65

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS: 4924 Lanier Ave. Balto. 15, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/11/65	SHAAREI ZION	ROSEDALE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 13 1965	Robert E. Farley, M.D.	SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-5531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5064 Registered No. 65 5064

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): KAMINETSKY, Jacob

2. DATE AND HOUR OF DEATH: May 11, 1965 | 3.50 a M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): LEVINDALE, HEBREW HOME AND INFIRMARY

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 5-12
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 3705 TOWANDA AVENUE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	White	WIDOWED		85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
PROPRIETOR	TIN SMITH	RUSSIA	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
UNKNOWN	UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		MR. DAVID KOMINS	4508 SPRINGDALE AVE

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 493X I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. UREMIA

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-31-1962 to 5-11-1965, that (I) (we) last saw the deceased alive on 5-11-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
Dr Ruth Willner		X	☐	☐	5-11-65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
RUTH WILLNER		LEVINDALE, HEBREW HOME AND INFIRMARY

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/12/65	OHR KNESSETH ISRAEL ANSHE SFARD	BALTIMORE MARYLAND

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	Robert E. Foster, M.D.	SOL LEVINSON & BROS. INC.	6010 REISTERSTOWN RD

VS 150-REV. 1/1/65

DAA
SAB

1

S-100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.
M.E. CASE NO. 65 5065

Registered No. 65 5065

1. NAME OF DECEASED (Type or Print): James Shea

2. DATE AND HOUR OF DEATH: 5-9-1965 8.25 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 24-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4233 Shamrock Ave 21206

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	1-23-1887	78				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bartender	Highland Cafe	Maryland	U.S.A.

13. FATHER'S NAME: - Shea

14. MOTHER'S MAIDEN NAME: - Treadwell

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	213-05-1866	Records: BCH	4940 Eastern Avenue

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. 420.1 I	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction	8.25 PM
	DUE TO	
	DUE TO	
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

MEDICAL EXAMINER'S CASE — M.D. — CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-9- 19 65 to 5-9- 19 65, that (I) (we) last saw the deceased alive on 5-9- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE					23B. DATE SIGNED
Philip Zieve	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	5-9-1965

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Dr. Philip Zieve M.D.	4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-13-65	Gardens of Faith Cem.	Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	Robert E. Faber, M.D.	John C. Miller Inc.	6415 Belair Rd.

VS 150-REV. 1/1/65

S-160 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5066 Registered No. 65 5066

1. NAME OF DECEASED (Type or Print): MRS. VIRGIE LORRETTA SHEAFFER
2. DATE AND HOUR OF DEATH: May 8, 1965 | 2 P.M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND
   FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 40 St. Agnes Hospital
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
   A. STATE: Maryland B. COUNTY: 25-43
   C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
   D. STREET ADDRESS (If rural, give location): 2722 Marbourne Avenue Balto. 21230
5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: July 14, 1899
9. AGE (In years last birthday): 65 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Weaver
10B. KIND OF BUSINESS OR INDUSTRY: Cotton Mill
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: Nevitt Ward Brooks
14. MOTHER'S MAIDEN NAME: Florence Estella Peters
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 215-07-6514
17. INFORMANT: Charles T. Sheaffer ADDRESS: 2722 Marbourne Ave, Balto.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) DUE TO: Electrolyte Imbalance — 3 days
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(B) DUE TO: Intestinal obstruction — 3 days
(C): Cancer of Bowel — 14 mo

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Cardiac failure

19A. DATE OF OPERATION: Jun 1964
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Ca of Bowel
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from for 1964 to May 7th 1965, that (I) (we) last saw the deceased alive on Apr 26 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Cliff Ratliff Jr. M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 5/10/65
23C. PHYSICIAN'S NAME (Type): CLIFF RATLIFF, JR. M.D.
23D. ADDRESS: 4605 Edmondson Ave 21229

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12 May 65
24C. NAME of CEMETERY or CREMATORY: Woodlawn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Co., Maryland

25A. DATE REC'D BY HEALTH DEPT.: MAY 13 1965
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR ADDRESS: Burgee Funeral Home 3631 Falls Rd. Balto. Md.
By: Horace A. Burgee

VS 150-REV. 1/1/65

1

W-325

BIRTH NO. 65 5067

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5067

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JAMES WOODSON	2. DATE AND HOUR PRONOUNCED DEAD: May 11, 1965 9:20 p M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Hopkins Hospital	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 5-01 D. STREET ADDRESS (If rural, give location): 1200 Canal Ct. Apt. 3B

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
male	colored	Widowed	Aug. 9. 1894	70				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Rod Carrier	Buckingham Co. Va.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jerry Woodson	Julie ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no —	217-09-1805	Christina Johnson	2117 Walbrook Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease

DUE TO

ANTECENDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) Rudiger Breitenecker M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 5-12-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	May 15 1965	Arbutus Mem. Park	Arbutus Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	Robert E. Farley M.D.	Earl Gilmore	1827 W. North Ave

VS 151-REV. 1/1/65

L-120 1

5-11-65. RELEASED AS NON MED

FUNERAL DIRECTOR: IMPORTANT BY DR. CENDANA • M.E.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5068 Registered No. 65 5068

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) LOBAS, Lessie

2. DATE AND HOUR OF DEATH May 11, 1965 | 10:50 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY 1122 Hanzlik Ave Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 6, Maryland
D. STREET ADDRESS (If rural, give location)

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	MARRIED	7-23-26	38				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		West Virginia	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
PATTERSON BAILEY,	NANCY.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	James Lobas	1122 Hanzlik Ave. Balto. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
I (A)	Metastatic Ca of lung	2/64
DUE TO (B)	Ca of cervix	7/22/63
DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Pneumonitis	

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
—	—	—	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	—	

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?
—		—

22. I certify that (I) (~~this hospital~~) attended the deceased from 10:31 AM 5/11 1965 to 10:50 AM 5/11 1965, that (I) (~~we~~) last saw the deceased alive on 10:50 AM 5/11 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE				23B. DATE SIGNED
Thomas A Hendrick M.D.	Attending Phys. X	Med. Director ☐	Staff Phys. ☐	5/11/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
THOMAS A. HANDRICH M.D.	JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-15-65	Panther Cemetery	Panther, West Virginia

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 13 1965	Robert E. Farley, M.D	Philip E. Cvach 1211 Chesaco Ave. Balto. Md

VS 150-REV. 1/1/65

K-2627 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5069 Registered No. 65 5069

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): (Dora) Victoria Kosiorek

2. DATE AND HOUR OF DEATH: May 7, 1965 6:30 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 2603 Fait Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 104
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2603 Fait Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Married	Dec. 1, 1894	70 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Pennsylvania	U. S. A.

13. FATHER'S NAME: Thomas Rush

14. MOTHER'S MAIDEN NAME: Mary Kilian

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Mr. Phillip Kosiorek	2603 Fait Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) DUE TO: Arteriosclerotic Cardio-vascular Disease	14 yrs.
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(B) DUE TO:	
	(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Diabetes Mellitus	12 yrs.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (~~this hospital~~) attended the deceased from March 1953 to May 1965, that (I) (~~we~~) last saw the deceased alive on May 5 1965 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
Clarence W. LeDoux M.D.	Attending Phys. X ☐ Med. Director ☐ Staff Phys. ☐	5/8/65

23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS
Clarence W. LeDoux M.D.		3023 Eastern Ave.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	May 10, 1965	Holy Rosary Cemetery	Baltimore County, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	E. Farber M.D.	Raymond L. Kaczorowski	2525 Fleet Street

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-540 1

BIRTH NO. 65 5070 Daniel

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 5070

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Daniell, Agnes Anna

2. DATE AND HOUR OF DEATH: May 11, 1965 | 12:50 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 04
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21224
D. STREET ADDRESS (If rural, give location): 819 S. Lakewood Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Married	January 9, 1906	59				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Homemaker	--	Baltimore, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Louis Skweres	Mary Zapper

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Andrew J. Daniel	819 S. Lakewood Ave.

MEDICAL CERTIFICATION

18. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: Myocardial infarction, acute.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO:

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 8, 1965 to May 11, 1965, that (I) (we) last saw the deceased alive on May 11, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
Manuel S. Gongon					May 11, 1965

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Manuel S. Gongon,		1400 N. Caroline St., Baltimore, Md. 21213

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	May 14, 1965	Holy Cross Cemetery	German Hill Rd. Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	Robert E. Faikeyn	Dippel Brothers	1800 E. Lombard St. 21231

VS 150-REV. 1/1/65

M-630 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5071 Registered No. 65 5071

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Joseph Moreida

2. DATE AND HOUR OF DEATH: May 11-65 7.50 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location): Lutheran Hospital of Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 15-38
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3024 W. Hamman BLVD.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M.	W.		1879	85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Retired	U.S.A.

13. FATHER'S NAME: Berl Marcida

14. MOTHER'S MAIDEN NAME: Dobra Tzeal

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Evelyn Krislov	3021 W. Garrison Blvd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) DUE TO: Cerebrovascular accident
(B) DUE TO: Probably Thrombosis due to ASCVD.
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 21 1965 to May 11 1965, that (I) (we) last saw the deceased alive on May 11 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE				23B. DATE SIGNED
Soon Sueck Lee M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☑	May-11 65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Soon Sueck Lee M.D.	Lutheran Hospital of Md

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	May 11, 1965	Ridge Rd #1 Cemetery	Cleveland, Ohio

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	Robt E. Fader, M.D.	Jack Fenn Inc.	2100 Eutaw Pl Baltimore Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-4601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5072 Registered No. 65 5072

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EDWARD L. SAYLOR

2. DATE AND HOUR OF DEATH: MAY 11, 1965 | 8:00 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):
ST. AGNES HOSPITAL
WILKENS & CATON AVENUE
BALTIMORE 29, MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21228
D. STREET ADDRESS (If rural, give location): 902 BARDSWELL ROAD

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
MALE	WHITE	MARRIED	3-18-08	57				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
TRUCK DRIVER	TRANSPORTATION EASTERN STATES	MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jacob F. Saylor	EMELIA CHARLOTTE Seidel

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	212-03-9031	ST. AGNES HOSPITAL, WILKENS & CATON AVE	

MEDICAL CERTIFICATION

18. 260X 1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Peritonitis due to Gastro duodenal
DUE TO Post gastric Surgery fistula
Peptic ulcer (gastric)

(B) DUE TO

(C) Diabetes

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
4-28-65	Poor	NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from APRIL 8 19 65 to MAY 11 19 65, that (I) (we) last saw the deceased alive on MAY 11 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J M Marchena MD M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ — 23B. DATE SIGNED: 5-11-65

23C. PHYSICIAN'S NAME (Type): Octavio de Marchena M.D. — 23D. ADDRESS: ST. AGNES HOSPITAL, WILKENS & CATON AVE.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5-15-65	Lornaine Park Cemetery	Woodlawn, Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	Robert E. Faherty	Wm. Cook-Brooks, Inc.,	1217 St. Paul Street

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-445 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5073 — Registered No. 65 5073

1. NAME OF DECEASED (Type or Print): GEORGE L. WILHELM
2. DATE AND HOUR OF DEATH: 5 | 10 | 65 — 5:20 A M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): UNIVERSITY HOSPITAL
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD — B. COUNTY: 2702
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO.
D. STREET ADDRESS (If rural, give location): 4707 HAMPNETT RD.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W		11 | 22 | 07	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Baker		Baltimore, Maryland	U.S

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George W. Wilhelm	Mary Mason

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — ADDRESS
	none	Mrs. Mary Wilhelm, 2205 Firethorn Rd., Zone 20

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) — CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

161 X I

(A) PNEUMONIA, RML, RLL — OUE TO — ?
(B) ASPIRATION — OUE TO
(C) CA OF ? LARYNX

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. — CA OF LARYNX, PHARYNX — ?

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5 | 7 | 19 65 to 5 | 10 | 19 65, that (I) (we) last saw the deceased alive on 5 | 10 | 19 | 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.O.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
R. Luddy					5/10/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
R. LUDDY		UNIVERSITY HOSP

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5-13-65	Moreland Memorial Cemetery	Baltimore

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR — ADDRESS
MAY 13 1965	Robert E. Farley, M.D.	Wm. Cook-Brooks Hamilton, Inc., 6009 Harford Rd

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. [redacted] 65 5074 Registered No. 65 5074

FILE CASE NO.

1. NAME OF DECEASED (Type or Print) MOORE, MARY ALICE

2. DATE AND HOUR OF DEATH 5-8-65 9:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location)

ST. AGNES HOSPITAL
BALTIMORE, MARYLAND

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MARYLAND B. COUNTY 27-38

C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE

D. STREET ADDRESS (If rural, give location) 1931 SWANSEA ROAD

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	WHITE	SINGLE	12-22-79	85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE (RETIRED SEC'Y)	USF&G Co.	MARYLAND	U.S.

13. FATHER'S NAME WILLIAM MOORE (DEC'D)

14. MOTHER'S MAIDEN NAME SOPHIA (DEC'D) UTTERBAUGH

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO			ST. AGNES HOSPITAL RECORDS BALTO. 29, MD

MEDICAL CERTIFICATION

18. 443X 1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO CVA

(B) DUE TO HCVHD

(C)

INTERVAL BETWEEN ONSET AND DEATH

Days

years.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-4 1965 to 5-8 19 65, that (I) (we) last saw the deceased alive on 5-8 19 65 and that to(my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. XXXXX

23A. SIGNATURE Richard J. Kelly M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED 5/8/65

23C. PHYSICIAN'S NAME (Type) RICHARD J. KELLY, MD M.D.

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/12/65	DRUID RIDGE CEM.	PIKESVILLE, MD.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 13 1965	Robert E. Falkenhan M.D.	H.W. MEARS & SON 805 N. CALVERT ST.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Su... written approval must be obtained before the remains are embalmed or final disposition is made.

B-2227 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5075 Registered No. 65 5075

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Alfred G. Buck

2. DATE AND HOUR OF DEATH: May 11, 1965 | 4:30 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 4303 Belvieu Ave

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 28-41
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21215
D. STREET ADDRESS (If rural, give location): 4303 Belvieu Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	Apr. 6, 1879	86				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Night Manager	Temple Garden Apt.	Rochester, N.Y.	U.S.A

13. FATHER'S NAME: Buck (First name unknown)

14. MOTHER'S MAIDEN NAME: Mary Sweet

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217-07-0593

17. INFORMANT: Nellie M. Buck, ADDRESS: 4303 Belvieu Ave. Baltimore, Md. 21215

CAUSE OF DEATH

18. 153.8 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO	Generalized Metastatic Ca.	1 year
(B) DUE TO	Carcinoma of lung, bronch	1 year.
(C)		

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/24 1942 to 5/11 1965, that (I) (we) last saw the deceased alive on 5/10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☒	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
A. A. Silver M.D.					5/12/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
A. A. SILVER M.D.		2601 MADISON AVE, BALTIMORE, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	May 13, 1965	Loudon Park	Baltimore, 21229, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	Robert E. Fabian M.D.	Harry McNamara	4204 Ridgewood Ave. Baltimore, Md. 21215

VS 150-REV. 1/1/65

1

C-462

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 65 5076 Registered No. 65 5076

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CHARLES CLARK

2. DATE AND HOUR PRONOUNCED DEAD: 5-10-65 1:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 5310 Denmore Ave. Baltimore 15 Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Westminster
D. STREET ADDRESS (If rural, give location): Manchester Road

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Colored	never married	12/9/18	46				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
laborer	farming	Carroll Co., Maryland	U.S.A.

13. FATHER'S NAME: Frank Clark

14. MOTHER'S MAIDEN NAME: Bertha Bowman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes W W II	218-01-7205	Mrs. Marie E. Owens	5310 Denmore Ave. Baltimore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lobar pneumonia
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Fatty liver

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: P W Rieckert M.D.

EXAMINER'S NAME (Type): PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED: 5-10-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
burial	5/15/65	Western Chapel Cemetery	New Windsor Rd., Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	Robert E. Faber, M.D.	J. E. Snyers, Jr.	Westminster, Md.

VS 151-REV. 1/1/65

1

H-350

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 65 5077 Registered No. 65 5077

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) JENNETTE MARGARET JEANETTE HATTON

2. DATE AND HOUR PRONOUNCED DEAD: May 12, 1965 5:15 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): South Baltimore General

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: AA
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Severn
D. STREET ADDRESS (If rural, give location): Crestwood Cresswood Trailer Park (Lot 20)

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
female	white	married	3/5/19	46				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Saleslady	Charleroi Hardware	Charleroe, Pa.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William McGinty	Mary Walker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Wm. A. Hatton, husband, above	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic cardiovascular disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) Rudiger Breitenecker M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED 5-12-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/15/65	Vel Vernon Cemetery	Bel Vernon, Pa.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 13 1965	Robert E. Farley, M.D.	Schimunek Funeral Home, Inc. 3331 Brehms Lane

VS 151-REV. 1/1/65

1

B-652

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 5978 (2418367)

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5078

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): DENEEN BARNES

2. DATE AND HOUR PRONOUNCED DEAD: 5-10-65 4:15 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): PROVIDENT HOSPITAL

39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-01
D. STREET ADDRESS (If rural, give location): 1812 Bolton Street - 21217

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	Colored		7/12/64		9			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	U.S.A.

13. FATHER'S NAME: Charles Barnes

14. MOTHER'S MAIDEN NAME: Ruby Gibbs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Ruby Gibbs	1812 Bolton Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

E872.0 (1)

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Acute salicylate poisoning

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO:

(C):

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Home	1812 Bolton Street 14-01

21D. TIME OF INJURY (APPROX.) (Month)	(Day)	(Year)	(Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
5	9	'65	? m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Ingested Oil of Wintergreen

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: [signature] M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
ASSOCIATE MEDICAL EXAMINER [X]

EXAMINER'S NAME (Type): PETER W. RIECKERT, M.D.

DATE SIGNED: 5-10-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/13/65	Mt. Auburn	Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 13 1965	Robert E. Farley, M.D.	Charles A. Rice 661 W. Barre St.

VS 151-REV. 1/1/65

N972.0

G-435 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 64-29839 65 5079 Registered No. 65 5079

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) TERRI A. GLADDEN

2. DATE AND HOUR OF DEATH MAY 11 1965 | 1:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 2628 RIDGHEY ST. Ridgely

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	N	NEVER MARRIED	11/1/64	1/24 yr.	6			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		BALTIMORE	USA

13. FATHER'S NAME WILLIAM FITZGERALD

14. MOTHER'S MAIDEN NAME ELOUISE GLADDEN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		MOTHER	2628 RIDGHEY ST.

MEDICAL CERTIFICATION

18. 279.01

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DEHYDRATION — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO ASPIRATION

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		YES	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 9 1965 to May 10 1965, that (I) (we) last saw the deceased alive on May 10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
Martin L. Epps		☐	☐	☑	5/11/65

23C. PHYSICIAN'S NAME (Type) M.D. 23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/13/65	Mt Auburn	Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	Robert E. Farley M.D.	Charles A. Rice	661 W. Barre St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

MA-210 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

BIRTH NO. 65 5080 Registered No. 65 5080

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): McCabe, Walter Joseph

2. DATE AND HOUR OF DEATH: 5/11/65 | 11:45 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location): Johns Hopkins Hospital

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: W. Va. B. COUNTY

V-6/5

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Wheeling

D. STREET ADDRESS (If rural, give location): 14 Pine Lane

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	Married	06-21-05	59				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Owner - Cleaning Plant		Marietta, Ohio	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOHN McCabe	MARY COLEMAN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Johns Hopkins Hospital Records	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
I	(A) Pulmonary embolus	2 hr.
	DUE TO (B) Venous thrombosis	?
	DUE TO (C) Post-operative recovery	10 days
II	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
4/29/65; 4/30/65	Bronchogenic carcinoma	No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 4-16 19 65 to 5-11 19 65, that ~~(I)~~ (we) last saw the deceased alive on 5-11 19 65 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) (did not) view the body after death.

23A. SIGNATURE: JR Beacon M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED: May 11, 1965

23C. PHYSICIAN'S NAME (Type) M.D. 23D. ADDRESS: Johns Hopkins Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	5/11/1965		Wheeling, West Virginia

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	Robert E. Fisher, M.D.	Wm. J. Fichman & Sons	Balto., Md. 21217 North Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V-162 1

BIRTH NO. 65-12307 65 5081

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 5081

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Baby Boy Jefferies

2. DATE AND HOUR OF DEATH: 5/10/65 | 6 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): Bon Secours Hospital Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 21-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1153 Sargent St (23)

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 1 Yr. Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.
Male	White	baby	5/9/65				19	39

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
child	none	Md.	U.S.A.

13. FATHER'S NAME: Norman B. Jefferies SR.

14. MOTHER'S MAIDEN NAME: Shirley White

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Norman R. Jefferies Jr. ADDRESS: 1153 Sargent St

MEDICAL CERTIFICATION

18. 762.51
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH
(A) Respiratory Insufficiency
DUE TO
(B) Primary atelectasis
DUE TO
(C) Prematurity

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 9 19 65 to May 10 19 65, that (I) (we) last saw the deceased alive on May 10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Francisco Baltazar, Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: May 10, 1965

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS: 2025 W. Fayette St. Balto. Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/12/65	Glen Haven Mem.	Glenburnie, Md.

25A. DATE REC'D BY HEALTH DEPT.: MAY 13 1965

25B. NAME OF REGISTRAR: Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR: John J. Cowan & Son, Inc. ADDRESS: 901 Hollins St (23)

VS 150-REV. 1/1/65

W-2001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5082 Registered No. 65 5082

1. NAME OF DECEASED (Type or Print): CLEMENTINE WEEKS

2. DATE AND HOUR OF DEATH: May 7, 1965 | 9 a. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): So. Baltimore Gen. Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 25-04
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3601 Ninth St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Married	Aug. 6, 1891	73 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Alabama	U. S.

13. FATHER'S NAME: Collins

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Mr. Paul A. Weeks	Same

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH,

(A) DUE TO: Arteriosclerotic heart disease

(B) DUE TO: Hypertension

(C):

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: osteoarthritis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Aug 10 1964 to May 7 1965 that (I) (we) last saw the deceased alive on 4/7/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Samuel Rubin M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: May 8, 1965

23C. PHYSICIAN'S NAME (Type): Samuel Rubin M.D.

23D. ADDRESS: 201 E. Patapsco Ave. Baltimore, Md. 21225

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	May 11, 1965	Holy Cross Cem.	Ritchie Hwy. A. A. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	Robert E. Farley M.D.	George J. Gonce	4001 Ritchie Hwy. (21225)

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

L-550

BIRTH NO. 65 5083

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5083

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LEMUEL L. LOWMAN

2. DATE AND HOUR PRONOUNCED DEAD: 5-9-65 | 12:20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): UNIVERSITY HOSPITAL

38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: GG
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Odenton
52-00
D. STREET ADDRESS (If rural, give location): 370 Baltimore Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	married	4/16/1899	66				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
ret. lineman	electric	Odenton, Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Fulton Lowman	Idella Lowman Lowman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		Elsie R. Lowman-wife-same as #4

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

E936 X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ~~XXXXX~~ Gunshot wound of head with subdural hematoma

ANTECENDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): In bedroom at 370 Baltimore Avenue, Odenton, Maryland

21D. TIME OF INJURY (APPROX.): (Month) 5 (Day) 8 (Year) '65 (Hour) 4:30 PM m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Shot self with 22 cal. Winchester rifle

22. I certify that I hold an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [X] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: P W Rieckert M.D.

EXAMINER'S NAME (Type): PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
ASSOCIATE MEDICAL EXAMINER [X]

DATE SIGNED: 5-10=65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/12/65	Epiphany Cemetery	Odenton Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 13 1965	Robt E. Faber M.D.	Beverly E. Hopping HOPPING FUNERAL HOME, Annapolis, Md.

VS 151-REV. 1/1/65

N 53-7.4

S-60 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65-11351 65 5084 Registered No. 65 5084

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SAWYER, BOY

2. DATE AND HOUR OF DEATH: 5-11-65 1:50A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 25-31
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE, 21229
D. STREET ADDRESS (If rural, give location): 4219 PARKTON STREET

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
MALE	WHITE	INFANT	5-6-65			5		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		MARYLAND	

13. FATHER'S NAME: LEONARD E SAWYER

14. MOTHER'S MAIDEN NAME: JANET D. HUDSON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		ST. AGNES RECORDS -	CATON & WILKENS AVES

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not meon the mode of dying, e.g., heart foilure, osthenio, etc. It means the diseose, injury or complicotion which coused deoth.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: (1) Bronchopneumonia, Right Upper Lobe 763.5 T
(2) Fetus Infectosus Neonatorum
(3) Prematurity

(B) DUE TO:

(C):

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if ony, giving rise to the obove couse (A) stoting the UNDERLYING CONDITION lost.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		YES	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Boltimore City, give exoct locotion)

21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from MAY 5 19 65 to MAY 11 19 65, that (I) (we) last saw the deceased alive on MAY 11 19 65 and that in(my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Edini V. J. Guerrero M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ — 23B. DATE SIGNED: May 11, 1965

23C. PHYSICIAN'S NAME (Type): GUERRERO M.D. — 23D. ADDRESS: ST. AGNES HOSPITAL, WILKENS & CATON AVE.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/12/1965	LOUDON PARK CEM.	BALTO. MD.

26A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	Robt E. Fabian, M.D.	G. TRUMAN SCHWAB	3512 FREDERICK AVE. (21)

VS 150-REV. 1/1/65

L-200 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5085 Registered No. 65 5085

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ALBERT MG. LEWIS Sr.

2. DATE AND HOUR OF DEATH: 5-6-65 | 11 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto. County
D. STREET ADDRESS (If rurol, give locotion): Box 299 C - Ridge Rd. - RFD #2

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	12-25-1899	65				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Heater	Armco Steel	Balto. Md.	

13. FATHER'S NAME: George Lewis

14. MOTHER'S MAIDEN NAME: Morgan

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	212-05-6939	Helene Ann Lewis	Same

MEDICAL CERTIFICATION

18. 420.01

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if ony, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cardiac Arrest — min
DUE TO
(B) Pulmonary Embolus — hrs
DUE TO
(C) ASHD with atrial fibrillation — yrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol examiner)

21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)

21E. INJURY OCCURRED — While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-6 1965 to 5-6 1965, that (I) (we) last saw the deceased alive on 5-6 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: William R. Law M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 5-6-65

23C. PHYSICIAN'S NAME (Type): WILLIAM R. LAW M.D.

23D. ADDRESS: MERCY HOSP. BALTO, MD

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-10-65	Parkwood Cem.	Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	Robert E. Farley M.D.	John G. Miller Inc.	6415 Belair Rd.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

H-630

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 5086

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5086

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) RUSSELL HARDWAY	2. DATE AND HOUR PRONOUNCED DEAD May 11, 1965 7:35 A. M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 7-03 D. STREET ADDRESS (If rural, give location) 727 N. Patterson Park Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	Dec 8, 1908	57				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Steam Fitter Eng	St Joseph's Hospital	West Va	U. S. A.

13. FATHER'S NAME —

14. MOTHER'S MAIDEN NAME —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	235-03-9227	Charles Leggie	931 Hammond Lane

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) DUE TO Arteriosclerotic cardiovascular disease	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

422.1

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE John E. Adams M.D.

EXAMINER'S NAME (Type) John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 5-11-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5-14-65	Bel Air Memorial Gardens	Bel Air Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	Robert E. Faber M.D.	Jesse Cook	1701 N. Patterson Park Ave

VS 151-REV. 1/1/65

B-6251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5087 Registered No. 65 5087

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Garzymowski, Mary T.

2. DATE AND HOUR OF DEATH: 5/8/65 2:35 PM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): North Charles General Hosp. 4

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: City 6-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rurol, give locotion): 121 N. Curley St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years) lost birthdoy	If Under 1 Yr. Months / Doys	If Under 24 Hrs. Hours / Min.
Fe	Italian	Married	4-24-21	44		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Md.	U. S. A.

13. FATHER'S NAME: John Giordano

14. MOTHER'S MAIDEN NAME: Antionette Fratta

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dotes of service)

16. SOCIAL SECURITY NO.: 215-14-8876

17. INFORMANT: Hospital Record ADDRESS

MEDICAL CERTIFICATION

18. I

CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not meon the mode of dying, e.g., heort foilure, osthenio, etc. It meons the diseose, injury or complicotion which coused deoth.) 420.1	
(A) Acute myocardial infarct	1 hr.
DUE TO (B) Arteriosclerotic heart disease	yrs
DUE TO (C) Hypertensive CV disease	yrs
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if ony, giving rise to the obave cause (A) stoting the UNDERLYING CONDITION lost.	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol examiner)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Boltimore City, give exoct locotion)

21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospitol) ottended the deceased from May 10 19 57 to May 8 19 65, that (I) (we) last sow the deceased alive on 5/8/19 65 and that in (my) (our) opinion deoth occurred on the date and haur and from the causes stated obave. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: MARION FRIEDMAN M.D. Attending Phys. ☐ Med. Director ☒ Staff Phys. ☐ 23B. DATE SIGNED: 5/8/65

23C. PHYSICIAN'S NAME (Type): MARION FRIEDMAN M.D. 23D. ADDRESS: 5211 HARFORD ROAD BALTIMORE 14 Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/12/65	Holy Redeemer Cem.	Balto, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	Robert E. Farley, M.D.	Bernard Dabrowski Jr.	2114 E. Pratt St.

VS 150-REV. 1/1/65

1

B-452

BIRTH NO. 65 5088

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5088

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Robert JAMES R. BALLENGER

2. DATE AND HOUR PRONOUNCED DEAD: May 12, 1965 5:20 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

43

South Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-03

D. STREET ADDRESS (If rural, give location): 813 Fulton Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
male	colored	S	12-25-1931	33				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Welder	Steel	Spartensburg, S.C.	U.S.A.

13. FATHER'S NAME: Blise BALLenger

14. MOTHER'S MAIDEN NAME: Gertrude PAYTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Josephine Washington ADDRESS: 1726 Ld LANVale St.

MEDICAL CERTIFICATION

E909.3

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple traumatic injuries

DUE TO

ANTECENDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Shipbuilding	Maryland Dry Dock & Shipbuilding

25-06

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
5 12 65 4 & 4:30 a m	WHILE AT WORK ☒ NOT WHILE AT WORK ☐	Apparently fell

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) Rudiger Breitenecker M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 5-12-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
BURIAL	5-15-65	MT. AUBURN	Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	Robert E. Falkenhagen M.D.	Morton J. Dyett	1701 Laurens

VS 151-REV. 1/1/65

N 869.2

✓

1

L-008

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 5088 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No. 65 5089

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) CHARLES H. LEE	2. DATE AND HOUR PRONOUNCED DEAD 5-10-65 | 5:30 A M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. JOSEPH'S HOSPITAL - DOA	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 9-09 D. STREET ADDRESS (If rural, give location) 1536 Aisquith Street 21202

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	Colored	Married	9-9-1892	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retire		Virginia	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Henry Lee	Margaret

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	215-01-5240	Mary Lee	1536 N. Aisquith St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
I 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Arteriosclerotic cardiovascular disease	
DUE TO (B)	
ANTECENDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE PWRieckert M.D.

EXAMINER'S NAME (Type) PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED 5-10-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5-13-65	Balto National Em Balto	Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	Robert E. Farley M.D	Rayner Sanders	217 E Preston St

VS 151-REV. 1/1/65

1

W-252

BIRTH NO. 65 5090

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5090

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HARRY WASHINGTON	2. DATE AND HOUR PRONOUNCED DEAD: April 30, 1965 2:25 p M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Lutheran Hospital	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-01 D. STREET ADDRESS (If rural, give location): 11 N. Monroe St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.	12. CITIZEN OF WHAT COUNTRY?
male	colored			50			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Laborer		S. C

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — ADDRESS
		Matthews Dobbins 11 N. Monroe St

MEDICAL CERTIFICATION

CAUSE OF DEATH

	INTERVAL BETWEEN ONSET AND DEATH
18. 420.1 I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Arteriosclerotic cardiovascular disease	
DUE TO (B)	
ANTECENDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 5-1-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME OF CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5-10-65	Mt Calvary Cem. A.A. Co	Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	Robert E. Farley	Rayner Sanders	217 E Pre.t

VS 151-REV. 1/1/65

F-6761

BIRTH NO. 65 5091

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5091

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): FRAZIER Jumius

2. DATE AND HOUR OF DEATH: 5-8-65 4:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Union Memorial Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 12202
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 18
D. STREET ADDRESS (If rural, give location): 2427 Brentwood Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	C	MARRIED	8/5/88	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired.	-	VIRGINIA,	AMERICAN

13. FATHER'S NAME: ARCHIE FRAZIER

14. MOTHER'S MAIDEN NAME: JANE RONE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Hospital Record	

MEDICAL CERTIFICATION

18. 1222 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Bronchopneumonia, confluent
Due to
(B) Cor adiposum
Congestive heart failure
(C) Carcinoma of prostate gland
ARB

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
4-24-65	Ca of prostate	YES	YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No	-	-

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?
No.		-

22. I certify that (I) (this hospital) attended the deceased from 5-8 1965 to 5-8 1965, that (I) (we) last saw the deceased alive on 5-8 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ — 23B. DATE SIGNED: 5-8-65

23C. PHYSICIAN'S NAME (Type): DR. KOPITZ M.D. — 23D. ADDRESS: UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-12-65	Mt Auburn Cem	Balto Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	Robert E. Farber M.D.	Rayner Sanders	217 E. Preston St

VS 1S0-REV. 1/1/65

W-2561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5092 — Registered No. 65 5092

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): WAGNER, JACOB M.

2. DATE AND HOUR OF DEATH: 5-10-65 | 9 30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00
D. STREET ADDRESS (If rural, give location): 3205 RICHWOOD AVENUE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
MALE	WHITE	MARRIED	2-9-90	75				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck Driver		Austria	U.S.A.

13. FATHER'S NAME: Charles Wagner

14. MOTHER'S MAIDEN NAME: BARBARA HEINRICK

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	213-05-7963	Elsie Wagner	3205 Richwood Ave. #7

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
I	(A) ACUTE LEUKEMIA	1 MTH
	DUE TO	
II	(B) PSEUDOMONAS PNEUMONIA	1 WK.
	DUE TO	
	(C)	

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: H/O Ca LARYNX

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		YES	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from 4-23 19 65 to 5-10 19 65, that (I) (we) last saw the deceased alive on 5-10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
Paul D. Hart M.D.	Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒	5/10/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
PAUL D. HART M.D.	

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/14/65	Holy Redeemer Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	Robert E. Fahey, M.D.	E. Ellsworth Armacost	Ellsworth Armacost 4600 Liberty Heights

VS 150-REV. 1/1/65

M 6531

BIRTH NO. UNKNOWN 65 5093

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5093

RELEASED ON APPROVAL BY DR. FISCHER MEDICAL EXAMINER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

63-336

1. NAME OF DECEASED (Type or Print): MORANT, DONNA

2. DATE AND HOUR OF DEATH: 5-10-65 | 11:30 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 7-04
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 936 BOND ST.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	NEGRO	NEVER MARRIED	1-20-63	2 YRS		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Balto, Md.	

13. FATHER'S NAME: REGINALD MORANT

14. MOTHER'S MAIDEN NAME: BARBARA EGGELSTON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Reginald Morant ADDRESS: 936 Bond St

MEDICAL CERTIFICATION

18. E916.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) 40% BODY BURNS — 82 DAYS
DUE TO
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY M.D. CHIEF OR ASST. MEDICAL EXAMINER: [signature]

Congestive heart failure secondary to ventricular septal defect

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		YES	

21A. ACCIDENT WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): HOME

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 936 N. BOND ST. BALT., 5, MD.

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 2-17-65

21E. INJURY OCCURRED: While At Work [ ] Not While At Work [X]

21F. HOW DID INJURY OCCUR? HOME CAUGHT ON FIRE 07-04

22. I certify that (I) (X) (this hospital) attended the deceased from FEBRUARY 17 1965 to MAY 10, 1965, that (I) (~~me~~) last saw the deceased alive on MAY 10, 1965 and that in (my) (~~or~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~X~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: E. C Holmes M.D. Attending Phys. [ ] Med. Director [ ] Staff Phys. [X]

23B. DATE SIGNED: 5-10-65

23C. PHYSICIAN'S NAME (Type): E.C HOMES M.D.

23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/13/65	Baltimore Natl Cemetery	5501 Fredrick Ave.

25A. DATE REC'D BY HEALTH DEPT.: MAY 13 1965

25B. NAME OF REGISTRAR: R. L. & E. Fahey M.D.

25C. FUNERAL DIRECTOR: Milton E. Eichelson ADDRESS: 1129 W Lexington St

VS 150-REV. 1/1/65 N 948.2

A-5241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5094 — Registered No. 65 5094

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Anzalone, Segnorella

2. DATE AND HOUR OF DEATH: 5/4/65 — 10:50 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md — B. COUNTY: Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4151 Glen Park Rd

5. SEX: F — 6. RACE: W — 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) — 8. DATE OF BIRTH: 4/13/88 — 9. AGE (In years last birthday): 77 — If Under 1 Yr. Months / Days — If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework — 10B. KIND OF BUSINESS OR INDUSTRY: Home — 11. BIRTHPLACE (State or foreign country): Italy — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ANGELO — 14. MOTHER'S MAIDEN NAME: JOSEPHINE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No / No — 16. SOCIAL SECURITY NO.: — 17. INFORMANT: Mrs Lee Jones — ADDRESS: 4151 Glen Park Rd, Perry Hall Md

MEDICAL CERTIFICATION

CERTIFICATION APPROVED BY: [signature] M.D.
(CORONER / MEDICAL EXAMINER)

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	DUE TO	
ANTECEDENT CAUSES: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(B) DUE TO: Myocardial Infarction	1 hour
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION: 0 — 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — 20A. AUTOPSY? (Yes or No): NO — 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) — 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) — 21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐ — 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-4-65 WHEN THE PATIENT ARRIVED D.O.A. 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.
AT THE EMERGENCY DEPARTMENT

23A. SIGNATURE: John F Bigger, Jr MD M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ — 23B. DATE SIGNED: 5/4/65

23C. PHYSICIAN'S NAME (Type): JOHN F. BIGGER, JR M.D. — 23D. ADDRESS: Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial — 24B. DATE: 5/8/65 — 24C. NAME of CEMETERY or CREMATORY: Holy Redeemer — 24D. LOCATION (City, town, or county) (State): Baltimore 21206 — Md

25A. DATE REC'D BY HEALTH DEPT.: MAY 13 1965 — 25B. NAME OF REGISTRAR: Robert E. Farley, M.D. — 25C. FUNERAL DIRECTOR: Earl W. Clouston Funeral Home Inc. — ADDRESS: 6306 Belair Rd.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-340 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5095 — Registered No. 65 5095

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Howard Little

2. DATE AND HOUR OF DEATH: May 9, 1965 — 9:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 15-04
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1915 Herbert Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Col	Single	April 22, 1915	50				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		North Carolina	

13. FATHER'S NAME: James Little

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	244-10-8444	Mattie Lee Moses	1915 Herbert Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

443 X I

(A) DUE TO: Hypertensive Cardio Vascular Disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO:

(C):

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from 1-4 19 63 to 4-26 19 65, that (I) (we) last saw the deceased alive on 4-26 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☒	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
W Atwell Jones					5/12/65

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS: 534 Dolphin St

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	May 13, 65	Mt. Auburn Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 13 1965	Robt E. Tabb, M.D.	Arlington S. Phillips 1727 N. Monroe St.

VS 150-REV. 1/1/65

J-520 1

BIRTH NO. 65 5096

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5096

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): WALTER EDWARD JONES

2. DATE AND HOUR OF DEATH: 5-8-65 | 6:10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 15-47
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2923 WINDSOR AVE.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	NEGRO	MARRIED	1-23-13	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	U.S. Custom House	Baltimore, Md.	

13. FATHER'S NAME: WALTER E. JONES, SR.

14. MOTHER'S MAIDEN NAME: JULIE RINGOLD

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Rachel Jones	2923 Windsor ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I 153.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) METASTATIC CANCER OF COLON	2 YEARS
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(A) DUE TO	
	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from MARCH 24, 1965 to MAY 8, 1965, that ~~(I)~~ (we) last saw the deceased alive on MAY 8 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
Antonio Dalmerico					

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
ANTONIO DALMERICO ~~R.L. CALHOUN~~		THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-12-65	Arbutus Mem. Pk.	Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	R. Lee E. Farber M.D.	Arlington S. Phillips	1727 N. Monroe St.

VS 150-REV. 1/1/65

L-420 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5097 Registered No. 65 5097

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Theodore R. Lyles.

2. DATE AND HOUR OF DEATH: 8 May 65 | 9:20 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institutian, give street address or location): University Hosp. 3

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY: 15-11
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21215
D. STREET ADDRESS (If rural, give location): 3606 Copley Rd.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M.	C	Never Married	7.5.23	41				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Railway Postal Clerk	U.S.P.O.	Md	USA.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Theodore Lyles	Florence Dorsey

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	11		Mother.	Same

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: Uremia — 5 mo.

(B) DUE TO: Malignant hypertension (yr.

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from 4-27-65 19 to 5-8-65 19, that (I) (we) last saw the deceased alive on 5-8-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☑	23B. DATE SIGNED
D.R. Cain					5.8.65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
D. R. CAIN		Univ. Hosp

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-12-65	Baltimore National	Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	Robert E. Farley M.D.	Arlington S. Phillips	1727 N. Monroe St

VS 150-REV. 1/1/65

V-45211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 3 65 5098 Registered No. 65 5098

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Gladys E. Valenzia

2. DATE AND HOUR OF DEATH: May 9/65 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 744 S. Woodington Rd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 25-31
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 744 S. Woodington Rd.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Married	Jan. 18/06	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
H.W.	Own Home	Md.	USA

13. FATHER'S NAME: Thomas C. Davidson

14. MOTHER'S MAIDEN NAME: Gertrude Johnson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 216 03 4440

17. INFORMANT: Charles A. Valenzia, 744 S. Woodington ADDRESS RD. 29

MEDICAL CERTIFICATION

18. 1621 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Bronchogenic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 8 Months
DUE TO with metastases

(B)
DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 10 1965 to May 9 1965, that (I) (saw) last saw the deceased alive on May 9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John F. Coolahan M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐ 23B. DATE SIGNED: 5/12/65

23C. PHYSICIAN'S NAME (Type): JOHN F. COOLAHAN M.D. 23D. ADDRESS: 4201 WILKENS AVE - 21229

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	May 13/65	Loudon Park	Balto. 29, Md

25A. DATE REC'D BY HEALTH DEPT.: MAY 13 1965 25B. NAME OF REGISTRAR: Robert E. Farley M.D. 25C. FUNERAL DIRECTOR, ADDRESS: Witzke F.D. 4101 Edmondson Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-2321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 3 65 5099 Registered No. 65 5099

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Helena Ricketson

2. DATE AND HOUR OF DEATH: May 11/65 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2107 Wilkens Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 20-05
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2107 Wilkens Ave

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Widow	Feb. 4, 1875	90				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	N.Y.	USA

13. FATHER'S NAME: ——— Halbert

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Miss Pearl Long	2107 Wilkens Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 12 days

DUE TO

(B)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C) ARTERIOSCLEROSIS, GENERALIZED — 16 years.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from April 29, 1965 to May 11, 1965, that (I) (~~we~~) last saw the deceased alive on May 10, 1965 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☑	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
Gilbert E. Rudman,					5/13/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
GILBERT E. RUDMAN, M.D.	2517 W. BALTIMORE ST.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	May 13/65	Meadowridge Mem. Pk.	Dorsey, Md.	Howard Co.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	Robert E. Farley, M.D.	Witzke F.D.	4101 Edmondson Ave.

VS 150-REV. 1/1/65

A-4261

65-13865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5100 Registered No. 65 5100

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ALGER, BABY GIRL

2. DATE AND HOUR OF DEATH: 5-10-65 | 9:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: 15-02

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

D. STREET ADDRESS (If rural, give location): 1414 MONROE ST.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
FEMALE	WHITE	NEWBORN	5-10-65				9	27

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JOHN ALGER, JR.

14. MOTHER'S MAIDEN NAME: JOSEPHINE SALLY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ST AGNES HOSPITAL RECORDS, WILKINS AND CATON AVES. ADDRESS 21229

MEDICAL CERTIFICATION

18. 762.3 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO: Congenital Atelectasis

(B) DUE TO: Prematurity

(C):

INTERVAL BETWEEN ONSET AND DEATH: 9 h 27 min

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-10 19 65 to 5-10- 19 65, that (I) (we) last saw the deceased alive on 5-10- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Fe L. Rubin M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 5/10/65

23C. PHYSICIAN'S NAME (Type): FE RUBIN M.D.

23D. ADDRESS: ST AGNES HOSPITAL, BALTO. 29, MD.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/12/65	EVERGREEN	LURAY, VIRGINIA

25A. DATE REC'D BY HEALTH DEPT.: MAY 13 1965

25B. NAME OF REGISTRAR: R. Scott & E. Faber M.D.

25C. FUNERAL DIRECTOR ADDRESS: WITZKE FUNERAL DIRECTORS 4101 EDMONDSON AVE.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-56311

BIRTH NO. (6) 65 5101 M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5101

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): FINNERTY, EDWARD C.

2. DATE AND HOUR OF DEATH: 5-12-65 | 2:15A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 16-06
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2909 W. MOSHER STREET

40

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	WHITE	MARRIED	9-9-02	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Westinghouse	MARYLAND	U S A

13. FATHER'S NAME: WILLIAM FINNERTY

14. MOTHER'S MAIDEN NAME: SARAH Hilda Finnerty Wife

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 212-16-8516

17. INFORMANT: ST. AGNES RECORDS -CATON & WILKENS ADDRESS ARES.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) DUE TO: Carcinoma of Prostate

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(B) DUE TO:
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from MAY 10 19 65 to MAY 12 19 65, that (I) (we) last saw the deceased alive on MAY 12 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Raphael C. Myers Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED: 5/12/65

23C. PHYSICIAN'S NAME (Type): RAPHAEL C MYERS, JR M.D. 23D. ADDRESS:

24A. BURIAL CREMATION, REMOVAL (Specify): Burial 24B. DATE: 5/14/65 24C. NAME of CEMETERY or CREMATORY: New Cathedral 24D. LOCATION (City, town, or county) (State): Balto. Md

25A. DATE REC'D BY HEALTH DEPT.: MAY 13 1965 25B. NAME OF REGISTRAR: Robert E. Farley M.D 25C. FUNERAL DIRECTOR: Wolfe F.D. ADDRESS: 4101 Edmondson Ave

VS 150-REV. 1/1/65

F-5201

BIRTH NO. 65 5102

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5102

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): IOLA E. FENWICK

2. DATE AND HOUR OF DEATH: MAY 11, 1965 | 5 30 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1236 W. LANVALE STREET BALTIMORE, MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: 16-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1236 W. LANVALE STREET

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
FEMALE	COLORED	MARRIED	11-22-1910	54				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE		CHARLOTTE, N. C.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JAMES ADAMS	DICIE CRAWFORD

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		IRVIN FENWICK	1236 W. LANVALE STREET

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Carcinoma Right Breast — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from 3/18 1958 to 5/11 1965, that (I) (we) last saw the deceased alive on 5/10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☑	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
Emerson R. Julian					5/12/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Emerson R. Julian		2329 Arunah Ave. Baltimore, Maryland

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	MAY 15, 1965	NEW CATHEDRAL	BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	Robert E. Falkner	CHARLES R. LAW	802 MADISON AVE.

VS 150-REV. 1/1/65

M-250 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5103 Registered No. 65 5103

1. NAME OF DECEASED (Type or Print) Rebecca Mason (or) BESSIE MASON

2. DATE AND HOUR OF DEATH 5-10-65 | 2:50 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location)
42
Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY 8-05
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.
D. STREET ADDRESS (If rural, give location) 1922 N. WASHINGTON ST. # 13

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthd	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	C	M	7/22/97	67				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	own home	Norfolk, Virginia	U.S.A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Armstead Howard	Eva Peoples

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	?	Claude Mason	1922 N. Washington St.

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Metastatic ca to pleura — 2 mos.
DUE TO Primary site, unknown
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/14 1965 to 5/10 1965, that (I) (we) last saw the deceased alive on 5/10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
Gerardo M. Ypil Jr.		☐	☐	☒	5/10/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
GERARDO M. YPIL JR.		SINAI HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	5-12-65	Calvary Cemetery	Norfolk, Va.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	Robert E. Farley, M.D	Randolph J. Collick	1412 E. Preston St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

SAB- 43-44-03

5-412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO. 65 5104

Registered No. 65 5104

1. NAME OF DECEASED (Type or Print): Augusto Silvestri

2. DATE AND HOUR OF DEATH: 5-11-1965 | 8.15 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 26-36

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1415 DeMarcay Way 21224

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	2-1-1903	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Labor	Contruction Work	Italy	U.S.A.

13. FATHER'S NAME: Vincenzo Silvestri

14. MOTHER'S MAIDEN NAME: Elizabeth ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 125-05-0147

17. INFORMANT: Records: BCH-4940 Eastern Avenue ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
I (A) DUE TO	Cardiac Arrest	4 minutes
(B) DUE TO	Cor Pulmonale	5 years
(C)	Chronic Obstructive Lung Disease	10 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Pneumonia	2 weeks

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-26- 19 65 to 5-11- 19 65, that (I) (we) last saw the deceased alive on 5-11 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Philip Zieve M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED: 5-11-1965

23C. PHYSICIAN'S NAME (Type): Dr. Philip Zieve M.D. 23D. ADDRESS: 4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
May-14-65 Burial	5/14-65	Holy Redeemer Cem.	4430 Belair Rd. Balt. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	Robert E. Farley M.D.	Frank Wallace	322 S. High St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-340 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5105 Registered No. 65 5105

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Sadie Elder Stehl

2. DATE AND HOUR OF DEATH: 5-13-65 7 45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Bal. 27-14
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 901 W. University Pkwy 10

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	W	7-8-1877	87				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	USA

13. FATHER'S NAME: Zachariah Elder

14. MOTHER'S MAIDEN NAME: Katherine Wiegner

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No None		Mr. Carl A. Stehl, Jr. 901 W. University Pkwy. Baltimore, Md. 21210

MEDICAL CERTIFICATION

18. 4221 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Diffuse Arteriosclerotic Cardio-
DUE TO
(B) Vascular Disease.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cachexia

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-11 1965 to 5-13 1965, that (I) (we) last saw the deceased alive on 5-13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
Rodney L. Brimhall M.D.	Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑	5-13-65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
RODNEY L. BRIMHALL M.D.	UNION MEMORIAL HOSPITAL Union Memorial Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/15/1965	Green Mount Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 13 1965	Robert E. Farley M.D.	Wm. J. Tichnor & Son Balto., Md. 2117 North Pa. Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

P-630

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 5106 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No. 65 5106

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EDWARD J. PERROTT

2. DATE AND HOUR PRONOUNCED DEAD: May 12, 1965 | 10:45 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 44 Union Memorial Hospiral

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-01
D. STREET ADDRESS (If rural, give location): 4706 Frankford Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 1 Yr. Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.
Male	White	married	8-24-1908	56				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
President Johnson	Metalcraft Co.	Ohio	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Perrott	Anna Karcher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	224012798	Mary N. Perrott	same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease.

DUE TO

ANTECENDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

420.0

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles Petty M.D.

EXAMINER'S NAME (Type) Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 5/13/65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
burial	5-17-65	Gardens of Faith	Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 13 1965	Robert E. Farley, M.D.	Leonard J. Ruck Inc Baltimore, Md.

VS 151-REV. 1/1/65

M-2000 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5107 Registered No. 65 5107

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print)	ELIZABETH G. MACK
2. DATE AND HOUR OF DEATH	5/12/65 | 12 20 A.M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion)	UNION MEMORIAL HOSPITAL
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	MD.
B. COUNTY	27-06
C. CITY OR TOWN (If outside city limits, write RURAL and give township)	BALTIMORE
D. STREET ADDRESS (If rural, give location)	5407 ELSRODE AVE
5. SEX	F
6. RACE	W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	SINGLE
8. DATE OF BIRTH	7/5/12
9. AGE (In years last birthday) / If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.	52
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	SALESLADY
10B. KIND OF BUSINESS OR INDUSTRY	DEPT. STORE
11. BIRTHPLACE (State or foreign country)	MD
12. CITIZEN OF WHAT COUNTRY?	U.S.A.
13. FATHER'S NAME	FREDERICK G. MACK
14. MOTHER'S MAIDEN NAME	BARBARA A. BRENNEIS
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	No —
16. SOCIAL SECURITY NO.	?
17. INFORMANT / ADDRESS	U.M.H. CHART / CITY

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not meon the mode of dying, e.g., heort foilure, osthenio, etc. It meons the diseose, injury or complicotion which coused deoth.) — INTERVAL BETWEEN ONSET AND DEATH

(A) METASTATIC ADENOCARCINOMA — OVER 6 MO

DUE TO

(B) PRIMARY ADENOCARCINOMA, SITE UNK — OVER 3 MO

DUE TO NOWN

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if ony, giving rise to the obove couse (A) stoting the UNDERLYING CONDITION lost.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
—	—	No	—

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer) —	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) —	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —
21D. TIME OF INJURY (Month) (Doy) (Yeor) (Hour) (APPROX.) —	21E. INJURY OCCURRED While At Work ☐ — Not While At Work ☐	21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 5/2/1965 to 5/12/1965, that (I) (we) last saw the deceased alive on 5/12/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE A. Laird Bryson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑	23B. DATE SIGNED	5/12/65
23C. PHYSICIAN'S NAME (Type) A. LAIRD BRYSON M.D.	23D. ADDRESS	UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)	
burial	5-15-65	Holy Redeemer Cemetery	Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS	
MAY 13 1965	Robert E. Farley, M.D.	Leonard J. Ruck Inc	Baltimore, Md.	

VS 150-REV. 1/1/65

1

W-300

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 65 5108 Registered No. 65 5108

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GEORGE WHITE	2. DATE AND HOUR PRONOUNCED DEAD: May 9, 1965 12:30 A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Sinai Hospital	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-15 D. STREET ADDRESS (If rural, give location): 2407 Bramble Road Brampleton

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	MARRIED	SEPT 21, 1887	77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
EXECUTIVE	DELIVERY COMPANY	NEW YORK	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
BENJAMIN F. WHITE	PHOEBE MACKINNON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	215-09-6520A	MR. GEO WHITE JR.	BOX 254 MANOR RD GLEN ARM, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease. — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECENDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Perineal Cellulitis.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Hospital	Sinai Hospital

21D. TIME OF INJURY (APPROX.) (Month)	(Day)	(Year)	(Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
5	4	'65	m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Fell out of bed.

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Petty M.D.

EXAMINER'S NAME (Type) Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 5/9/65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
BURIAL	MAY 11, 1965	DULANEY VALLEY CEM.	TIMONIUM, BALTIMORE COUNTY MARYLAND

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	Robert E. Farber M.D.	WM. COOK-BROOKS	1050 YORK RD TOWSON, MARYLAND

VS 151-REV. 1/1/65

N 996.1

1

H-561

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 65 5109 Registered No. 65 5109

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)	CHARLOTTE HAMMERBACHER
2. DATE AND HOUR PRONOUNCED DEAD	May 11, 1965 3:10 A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)	BALTIMORE CITY HOSPITALS
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	Maryland
B. COUNTY	Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	Baltimore Dundalk 5300
D. STREET ADDRESS (If rural, give location)	7910 St. Gregory Drive

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widowed	April 16 1906	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
? Haslup	Charlotte ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	217-18-0145	Son, Frederick Hammerbacher, # 4, a, b, c, d.	

MEDICAL CERTIFICATION

E 812.4

1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) — CAUSE OF DEATH: Craniocerebral injury — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
5-7-65	Head injury	Yes	Yes

21A. EXTERNAL CAUSE WAS ☒ UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Street	Dundalk Ave.. 143 ft. north of Holabird Ave. 26-36

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
5 7 65 6:00 P.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Pedestrian standing on sidewalk struck by automobile

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) John E. Adams M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 5-11-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	May 14-1965	Oak Lawn	Eastern Ave. Bal. Co. Md. 21222

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 13 1965	Robert E. Farley M.D.	JOHN J. DUDA 7922 Wise Ave. Dundalk, Md.

VS 151-REV. 1/1/65

N 836.2

B-635 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5110 — Registered No. 65 5110

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BORTMES, HAROLD F. / BORTMES, HAROLD, FRANCES

2. DATE AND HOUR OF DEATH: 10.45 AM 5/12/65

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): Union Memorial Hospital / Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore - 22 Dundalk 5300
D. STREET ADDRESS (If rurol, give locotion): 1932 Guyhavy 21222

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	3/11/09	56 Yrs				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Med. Dept. RN Nurse	Bethlehem Steel Co.	Butler, Pennsylvania	U.S.A. American

13. FATHER'S NAME: John Bortmes

14. MOTHER'S MAIDEN NAME: Mayme Slater

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Unknown	Navy 1930	213-07-9568	K M Anandaiah MD	Union Memorial Hosp

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not meon the mode of dying, e.g., heort foilure, osthenio, etc. It meons the disease, injury or complicotion which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above couse (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
I (A) DUE TO	Occlusion of Abdominal Aorta & both Iliac Arteries	5/3/65 - 5/12/65
(B) DUE TO	Respiratory arrest Secondary	
(C)	to Cerebral thrombosis.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
May 8. 1965	Occlusion of Abd aorta & both iliac arteries	NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Boltimore City, give exoct locotion)

21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify thot (I) (this hospitol) ottended the deceased from 5/3/ 19 65 to 5/12 19 65, thot (I) (we) lost sow the deceosed olive on 5/12/ 19 65 ond that in (my) (our) opinion deoth occurred on the dote ond haur ond from the couses stated above. (I) (We) (did) (did not) view the body ofter deoth.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☑	23B. DATE SIGNED
K. M. Anandaiah					5/12/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
K.M. ANANDAIAH / K.M. ANANDAIAH M.D.	Union Memorial Hospital. Baltimore

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	May 15-1965	Oak Lawn	Eastern Ave. Bal. Co. Md. 21222

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	Robert E. Farley M.D.	JOHN J. DUDA	7922 Wise Ave. Dundalk, 21222

VS 150-REV. 4/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-520 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

BIRTH NO. 65 5111 Registered No. 65 5111

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) CHARLES COMEGYS, SR. Charles Comegys, Sr.

2. DATE AND HOUR OF DEATH 5-11-65 7:00 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

University Hospital
University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md. B. COUNTY Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. - Dundalk

D. STREET ADDRESS (If rural, give location) 7621 South Bend Rd.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	5-2-03	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Steelworker – Retired	Armco Steel Co.	Wilmington, Del.	USA.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Clarence Comegys	Carrie A. Benson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	218-05-5344	Chas. H. & Wife Mary Comegys	Same

MEDICAL CERTIFICATION

CAUSE OF DEATH

	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	INTERVAL BETWEEN ONSET AND DEATH
1B. I (X)	(A) DUE TO Wide-Spread Metastases	several mos.
ANTECEDENT CAUSES	(B) DUE TO Renal cell carcinoma	Several mos.
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		YES	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 5-11 1965 to 5-11 1965, that ~~(I)~~ (we) last saw the deceased alive on 5-11 1965 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE D. Bernard Fleet M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED 5-11-65

23C. PHYSICIAN'S NAME (Type) D. BERNARD FLEET M.D. 23D. ADDRESS University Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	May 14-1965	Meadowridge Memorial	Washington Blvd. Dorsey Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 13 1965	R. L. & E. Farber M.D.	JOHN J. DUDA 7922 Wise Ave. Md. 21222

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-4561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5112 Registered No. 65 5112

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): PEARL ELIZABETH ELMORE

2. DATE AND HOUR OF DEATH: 5/12/65 3:20 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 36 FRANKLIN SQUARE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD B. COUNTY: 23-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 209 W. Mt. Chas ST. 30

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	W	5/12/65	63				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
H W		Md	USA

13. FATHER'S NAME: ALBERT SMITH

14. MOTHER'S MAIDEN NAME: JOANA WELSH

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Family	Same

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 163X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: WIDELY DISSEMIN.

(B) DUE TO: TB LUNG CA

(C):

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/4 19 65 to 5/12 19 65 that (I) (we) last saw the deceased alive on 5/12 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED: 5/12/65

23C. PHYSICIAN'S NAME (Type): P F BRIGHT M.D. 23D. ADDRESS: FSH

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
B	5/15/65	Loraine	Baltimore

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965	R. Burks E. Fosque	McCully - M.F.	130E Fort Ave. 30

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-200 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5113 Registered No. 65 5113

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Laura Casey

2. DATE AND HOUR OF DEATH: 5-10-65 | 10 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): LA Plaza Nursing Home 1515 N. Bruce ST

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY: 25-33
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2417 Paca St

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Fe	Col	Widow	2-14-85	80				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland AA Co.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Henson
14. MOTHER'S MAIDEN NAME: Martha Henson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Viola Savage ADDRESS: 7 W. Centalow St

MEDICAL CERTIFICATION

18. 493 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not meon the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complicotion which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: Myocardial Insufficiency — 4-22-65
(B) DUE TO: Cerebral arteriosclerosis
(C) Ess. Hypertension ?

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the obave couse (A) stoting the UNDERLYING CONDITION lost.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)
21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Boltimore City, give exact locotion)
21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-22- 196[illegible] to 5-10- 19 6[illegible]
that (I) (we) last saw the deceased alive on 5-10- 19 65 and thot in (my) (our) opinion death occurred on the date and hour and from the causes stoted obove. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [illegible] M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 5-11-6[illegible]
23C. PHYSICIAN'S NAME (Type): GEO. H. POINDEXTER M.D.
23D. ADDRESS: 1123 Druid Hill Ave

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-12-65	Mt Auburn	Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: MAY 13 1965
25B. NAME OF REGISTRAR: Robert E. Foster, M.D.
25C. FUNERAL DIRECTOR: Purnell C. Oden ADDRESS: Balto. Md

VS 150-REV.-1/3/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

H-635

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 65 5114 — Registered No. 65 5114

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): W. CHARLES HARTMAN

2. DATE AND HOUR PRONOUNCED DEAD: May 11, 1965 | 12:45 P M.

CERTIFICATE CORRECTED 5-21-65

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION: (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Below 4100 block of O'Donnell Street beside Pennsylvania Railroad Track ~~5201 Cardiff Avenue~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-36
D. STREET ADDRESS (If rural, give location): 5201 Cardiff Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Seperated	Aug. 11, 1896	68				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Carpenter		Baltimore, Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles W. Hartman	Margaret Bleckman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes 8-14-18 1-6-19	217-09-7567	Mrs Fredericka Hughes	121 Williams Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
I 430 X I 822.0	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) DUE TO: Hypertensive and arteriosclerotic cardiovascular disease	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO:	
(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Acute ethylism	

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: John E. Adams M.D.
EXAMINER'S NAME (Type): John E. Adams, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 5-11-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5-14-1965	St. Pauls	Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 13 1965 Robert E. Farley M.D.		Lilly & Zeiler Inc.	1901 Eastern Ave.

VS 151-REV. 1/1/65

Letter from M.E.'s office 5-21-65 M.H.

1

5-364

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 65 5115 Registered No. 65 5115

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WILLIAM SUTHERLAND

2. DATE AND HOUR PRONOUNCED DEAD: May 8, 1965 3:45 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Johns Hopkins Hospital

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-02
D. STREET ADDRESS (If rural, give location): 1434 E. Monument Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	Negro	married	Nov 6-1916	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steel Worker
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pulaski Co
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mattie Sutherland ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

E-900.0

(A) Subdural Hematoma and Contusions of ~~XXXXX~~ Brain.

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1434 E. Monument Street

21D. TIME OF INJURY (APPROX.)	(Month)	(Day)	(Year)	(Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	5	7	'65	P m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Fell down stairs. 10-02

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE EXAMINER'S NAME (Type): Charles S. Petty, M.D.
M.D. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] ASSOCIATE MEDICAL EXAMINER [ ]
DATE SIGNED: 5/9/65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town or county) (State)
Burial	5/15/1965	Antietam Cem	Balto Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 13 1965	R.L.S. & R. Farley, M.D.	Elroy O. Wilson

VS 151-REV. 1/1/65 N 8533.2

R-200 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65-10620 65 5116 Registered No. 65 5116

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BABY GIRL ROCK

2. DATE AND HOUR OF DEATH: 5/4/65 | 7 20 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Union Memorial Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY: Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO. #34
D. STREET ADDRESS (If rural, give location): 627 Haerner Ave

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	Single	5/4/65				1	30

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	USA

13. FATHER'S NAME: Dominic Rock

14. MOTHER'S MAIDEN NAME: Simone

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) HYDROPS fetalis
DUE TO
(B) Rh incomp.
DUE TO
(C) Prematurity

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/4 5 50 pm 1965 to 5/4 7 20 pm 1965, that (I) (we) last saw the deceased alive on 7 20 pm 5/4 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: E L Ledesma M.D. — M.D. ☐ Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ — 23B. DATE SIGNED: 5/4/65

23C. PHYSICIAN'S NAME (Type): ERNESTO L. LEDESEMA
ERNESTO L. LEDESMA M.D.

23D. ADDRESS: Union Memorial Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify) — 24B. DATE: MAY 13 1965 — 24C. NAME of CEMETERY or CREMATORY — 24D. LOCATION (City, town or county) (State)

ANATOMY BOARD OF MARYLAND
JOHNS HOPKINS MEDICAL SCHOOL

25A. DATE REC'D BY HEALTH DEPT.: MAY 14 1965 — 25B. NAME OF REGISTRAR: Robert E. Farley M.D. — 25C. FUNERAL DIRECTOR — ADDRESS: MORTUARY SERVICE - BCHD

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650 1

BIRTH NO. 65 5117

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 5117

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): William Brown

2. DATE AND HOUR OF DEATH: May 9, 1965 | 4:30 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital, 1514 Division Street, Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 14-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1215 North Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Negro	?	?	76				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		?	USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 163X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) R/O Right lung pneumonitis
DUE TO
(B) Carcinoma right lung
DUE TO
(C) Severe dehydration - Cachexia

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-8-65 19 to 5-9-65 19, that (I) (we) last saw the deceased alive on 5-9-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: R. Theodore M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 5-9-65

23C. PHYSICIAN'S NAME (Type): Roger Theodore M.D.

23D. ADDRESS: 1514 Division Street

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE: MAY 13 1965

24C. NAME of CEMETERY or CREMATORY: ANATOMY BOARD OF MARYLAND JOHNS HOPKINS MEDICAL SCHOOL

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.: MAY 14 1965

25B. NAME OF REGISTRAR: Robert E. Farkey M.D.

25C. FUNERAL DIRECTOR ADDRESS: MORTUARY SERVICE - BCHD

VS 150-REV. 1/1/65

M-2001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65-11816 65 5118 Registered No. 65 5118

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Baby of Emily McKoy (Twin # 2)

2. DATE AND HOUR OF DEATH: May 11, 1965 | 3:16a M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital, 1514 Division Street, Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 17-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 532 W. Lanvale Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	Negro	Single	May 11, 1965			20

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	USA

13. FATHER'S NAME: Jimmie McClellan

14. MOTHER'S MAIDEN NAME: Emily McKoy

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 762.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

(B) DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C) Atelectasis Neonatorum — INTERVAL BETWEEN ONSET AND DEATH: 30 minutes

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (1) Sub-arachnoid Hemorrhage (2) Twin Birth

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 11, 1965 19 to May 11, 1965 19, that (I) (we) last saw the deceased alive on May 11, 1965 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Vincent R Blake MD M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: May 12, 1965

23C. PHYSICIAN'S NAME (Type): Dr. Vincent Blake M.D.

23D. ADDRESS: 1514 Division Street

24A. BURIAL CREMATION REMOVAL (Specify)

24B. DATE: MAY 13 1965

24C. NAME of CEMETERY or CREMATORY: ANATOMY BOARD OF MARYLAND

24D. LOCATION (City, town, or county) (State): JOHNS HOPKINS MEDICAL SCHOOL

25A. DATE REC'D BY HEALTH DEPT.: MAY 11 1965 Robt E. Talbert

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR: MORTUARY SERVICE - BCHD ADDRESS

VS 150-REV. 1/1/65

A-2231

BIRTH NO. 65-10646 65 5119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5119

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): ACOSTA, Olga Ester

2. DATE AND HOUR OF DEATH: 4-27-65 | 9.45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Harford
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore Joppa, Md.
D. STREET ADDRESS (If rural, give location): 817 Forwell Court

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): —
8. DATE OF BIRTH: 4-27-65
9. AGE (In years last birthday): If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: 11 Min.: 45

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ACOSTA, Andres
14. MOTHER'S MAIDEN NAME: MARTINO, Laura

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Infomation from Chart. ADDRESS:

MEDICAL CERTIFICATION

1B. 773.01

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) HYALINE MEMBRANE D's.

INTERVAL BETWEEN ONSET AND DEATH: 11 hr. 45 min.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
DUE TO
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?: —

22. I certify that (I) (this hospital) attended the deceased from 4-27-65 19 to 4-27-65 19, that (I) (we) last saw the deceased alive on 4-27-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Carlos Abel M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4-27-65
23C. PHYSICIAN'S NAME (Type): CARLOS ABEL M.D.
23D. ADDRESS: UNIVERSITY HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify):
24B. DATE: MAY 12 1965
24C. NAME of CEMETERY or CREMATORY: ANATOMY BOARD OF MARYLAND
24D. LOCATION (City, town, or county) (State): UNIVERSITY MEDICAL SCHOOL

25A. DATE REC'D BY HEALTH DEPT.: MAY 14 1965
25B. NAME OF REGISTRAR: MAY 12 1965 R. Lewis Farley, M.D.
25C. FUNERAL DIRECTOR: MORTUARY SERVICE - BCHD ADDRESS:

VS 150-REV. 1/1/65

F-236 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65-11876 65 5120 Registered No. 65 5120

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Baby Boy FOSTER

2. DATE AND HOUR OF DEATH: 5-1-65 | 10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland - B. COUNTY: 15-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1542 N. Fulton Ave -

5. SEX: M
6. RACE: N
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): —
8. DATE OF BIRTH: 4-26-65
9. AGE (In years last birthday): If Under 1 Yr. Months: — Days: 5 | If Under 24 Hrs. Hours: | Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Milton Foster Jr.
14. MOTHER'S MAIDEN NAME: Joann Courtland Wallace -
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Information from chart. ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 759.3 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) MULTIPLE CONGENITAL
DUE TO
MALFORMATIONS -
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH: 5 days -

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 4-26-65 19 to 5-1-65 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Carlos Abel M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 5-1-65
23C. PHYSICIAN'S NAME (Type): CARLOS ABEL M.D.
23D. ADDRESS: University Hospital -

24A. BURIAL CREMATION, REMOVAL (Specify):
24B. DATE: MAY 12 1965
24C. NAME of CEMETERY or CREMATORY: ANATOMY BOARD OF MARYLAND
24D. LOCATION (City, town, or county) (State): UNIVERSITY MEDICAL SCHOOL

25A. DATE REC'D BY HEALTH DEPT.: MAY 14 1965
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: MORTUARY SERVICE - BCHD ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V-525 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65-10457 Registered No. 65 5121

M.E. CASE NO. 65 5121

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): JOHNSON, BABY BOY

2. DATE AND HOUR OF DEATH: 5/4/65 4:50 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL BALTO. MD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: BALTO CITY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 9-08
D. STREET ADDRESS (If rural, give location): 1926 KENNEDY AVE

5. SEX: M
6. RACE: N
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 4/30/65
9. AGE (In years last birthday): (If Under 1 Yr. Months: Days: 5 / If Under 24 Hrs. Hours: Min.:)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ~~EDITH V. PERKINS~~ JESSE JOHNSON
14. MOTHER'S MAIDEN NAME: ~~JESSIE~~ JOHNSON EDITH NOBLE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 773.5 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) RESPIRATORY FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 15 MIN.
DUE TO
(B) PREMATURITY — 5 DAYS
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/3 1965 to 5/4 1965, that (I) (we) last saw the deceased alive on 5/4 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Robert L. Gingell M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 5/4/65
23C. PHYSICIAN'S NAME (Type): ROBERT L. GINGELL, MD M.D.
23D. ADDRESS: UNIVERSITY HOSPITAL

24A. BURIAL CREMATION REMOVAL (Specify):
24B. DATE: MAY 12 1965
24C. NAME of CEMETERY or CREMATORY: ANATOMY BOARD OF MARYLAND
24D. LOCATION (City, town, or county) (State): UNIVERSITY MEDICAL SCHOOL

25A. DATE REC'D BY HEALTH DEPT.: MAY 14 1965
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: MORTUARY SERVICE - BCHD
ADDRESS:

VS 150-REV. 1/1/65

H-652 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65-09909 65 5122 Registered No. 65 5122

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): BABY GIRL HERRINGTON

2. DATE AND HOUR OF DEATH: 5-5-65 | 340 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 103
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 845 W. FRANKLIN STREET

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	N	—	4/25/65			10		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	MARYLAND	U.S.A.

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: BEATRICE HERRINGTON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: UNIVERSITY HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. 3403 1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) ACUTE PURULENT MENINGITIS — 12-24 hrs or more
DUE TO
(B) PREMATURITY — 10 days
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
—	—	YES	NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
—	While At Work ☐ Not While At Work ☐	—

22. I certify that (I) (this hospital) attended the deceased from 5/1 19 65 to 5/5 19 65, that (I) (we) last saw the deceased alive on 5/5 19 65 and that in (my) (our) opinion death occurred an the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Alice B. Heisler M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED: 5/5/65

23C. PHYSICIAN'S NAME (Type): Alice B. Heisler M.D. 23D. ADDRESS: UNIVERSITY HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify) 24B. DATE: MAY 12 1965 24C. NAME of CEMETERY or CREMATORY: ANATOMY BOARD OF MARYLAND 24D. LOCATION (City, town or county) (State): UNIVERSITY MEDICAL SCHOOL

25A. DATE REC'D BY HEALTH DEPT.: MAY 14 1965 25B. NAME OF REGISTRAR: Robert E. Farley, M.D. 25C. FUNERAL DIRECTOR: MORTUARY SERVICE - BCHD ADDRESS:

VS 150-REV. 1/1/65

W-3561

BIRTH NO. 65 5123

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5123

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Weidemeyer, Thomas E.

2. DATE AND HOUR OF DEATH: May 11, 1965 | 6.45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 7. 53-00
D. STREET ADDRESS (If rural, give location): 3110 Rolling Rd.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	married	7-15-1879	85				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mailman (Retired)
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Penna.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Peter Weidemeyer
14. MOTHER'S MAIDEN NAME: Mary ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NG.
17. INFORMANT: Emma Weidemeyer (wife) ADDRESS: Same

MEDICAL CERTIFICATION

1B. 420.0 7-15-7X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: ASHD & Mitral Insufficiency — 1 Month

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO: ~~Same~~ Carcinoma of body of pancreas

(C) Abdominal Carcinomatosis

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPRDX.)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-11 19 65 to 5-11 19 65, that (I) (we) last saw the deceased alive on 5-11 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Ey Kol Koh M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 5-11-65
23C. PHYSICIAN'S NAME (Type): Ey Kol Koh M.D.
23D. ADDRESS: Md. Gen. Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/14/65	WOODLAWN	WOODLAWN MD. (7)

25A. DATE REC'D BY HEALTH DEPT.: MAY 14 1965
25B. NAME OF REGISTRAR: Robert E. Farley M.A
25C. FUNERAL DIRECTOR: John T. Stansbury Rev. Chapel
ADDRESS: Windsor Mill Md.

VS 150-REV. 1/1/65

SAB-37-27-17 1

D-305

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5124 Registered No. 65 5124

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Oscar Dowdy

2. DATE AND HOUR OF DEATH: 5-12-1965 2.20A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 13-05
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 819 West 33rd. Street 21211

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Divorced	10-24-1908	57				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Printer	Jaffee Co	Virginia	U.S.A.

13. FATHER'S NAME: Oscar C. Dowdy.

14. MOTHER'S MAIDEN NAME: Lucille Skidmore.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes 2nd W.W.	—	Records: BCH	4940 Eastern Avenue 21224

MEDICAL CERTIFICATION

18. 299X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Intracranial Bleeding — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) Cirrhosis-bleeding

DUE TO

(C) Dyscrasia

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY Ooccur?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from 4-12- 19 65 to 5-12- 19 65, that (I) (we) last saw the deceased alive on 5-12- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
J.B. Zachary,		☐	☐	☒	5-12-1965

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Dr. J.B. Zachary		4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/15/65	New Cathedral	Old Frederick Rd, Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 14 1965	Robert E. Fahey, M.D.	Austin E. Donovan	3816 Roland Ave

VS 150-REV. 1/1/65

P-516 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65-05587 Registered No. 65 5125

M.E. CASE NO. 65 5125

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): ROBERT PEMBERTON III
2. DATE AND HOUR OF DEATH: MAY 12, 1965 | 1:45 A.M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND
   FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): SINAI HOSP.
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
   A. STATE: MARYLAND B. COUNTY: 13-07
   C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
   D. STREET ADDRESS (If rural, give location): 4115 FALLS ROAD
5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): SINGLE
8. DATE OF BIRTH: 3-5-65
9. AGE (In years last birthday):
   If Under 1 Yr. Months: 2 Days: Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CHILD
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?: U.S.
13. FATHER'S NAME: Robert Pemberton Jr.
14. MOTHER'S MAIDEN NAME: SANDRA L. MYERS
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADELAIDE MYERS ADDRESS: 2037 DAVID PARK DRIVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) SUBARACHNOID HEMORRHAGE DUE TO

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-7 1965 to 5-12 1965, that (I) (we) last saw the deceased alive on 5-12 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Amado Torres M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: May 12, 1965
23C. PHYSICIAN'S NAME (Type): AMADO P. TORRES M.D.
23D. ADDRESS: Sinai Hosp. of Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 5/14/65
24C. NAME of CEMETERY or CREMATORY: Lorraine Park
24D. LOCATION (City, town, or county) (State): Windsor Mill Rd, Md

25A. DATE REC'D BY HEALTH DEPT.: MAY 14 1965
25B. NAME OF REGISTRAR: R. W. A. E. Farber M.D.
25C. FUNERAL DIRECTOR: Austin E. Donovan ADDRESS: 3818 Pleasant Ave

VS 150-REV. 1/1/65

B-652 1

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 5126

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5126

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CLARENCE J. BARNES

2. DATE AND HOUR PRONOUNCED DEAD: May 12, 1965 9:20 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Baltimore City Hospitals

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-02
D. STREET ADDRESS (If rural, give location): 4365 Nicholas Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	married	June 27, 1914	50				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Inspector	Fischer Body	Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Barnes	Mary Quirk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes Army W.W.2	216-03-2594	Margaret Bartkovich Barnes,	wife, above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

420.0

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease.

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type): Charles S. Petty, M.D.

M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 5/13/65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/17/65	Balto. Nat. Cem.	Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 14 1965	Robert E. Farley, M.D.	Schimunek Funeral Home, Inc. 3331 Brehms Lane

VS 151-REV. 1/1/65

				married	
Inspector		Fischer Body		Baltimore, M	
Joseph Barnes				Mary Qui	
Yes	Army W.W.2	216-03-2594	Margaret Bar		

P-670 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.
M.E. CASE NO. 65 5127

Registered No. 65 5127

1. NAME OF DECEASED (Type or Print): Berrick, Margaret Marie

2. DATE AND HOUR OF DEATH: May 12, 1965 | 3:50 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): St. Joseph Hospital

4. USUAL RESIDENCE (Where deceosed lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 26-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21206
D. STREET ADDRESS (If rural, give locotion): 4530 Parkside Drive.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In yeors lost birthday)	If Under 1 Yr. Months / Doys	If Under 24 Hrs. Hours / Min.
Female	White	Married	8-20-1923	41		

10A. USUAL OCCUPATION (Give kind of work done during most working life, even if retired): Secretary Homemaker
10B. KIND OF BUSINESS OR INDUSTRY: Ins. Co. -Smith Sommerville Case
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry T. Sherry
14. MOTHER'S MAIDEN NAME: Margaret Roberts

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dotes of service):
16. SOCIAL SECURITY NO.: 217-16-8437
17. INFORMANT: Melvin Berrick, husband, above — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Sarcoma of right pleura; widespread matastasis.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(B) DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
March 13, 1965	Tumor of chest wall	Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED — White At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from February 18, 1965 to May 12, 1965, that (I) (we) last saw the deceased alive on May 12, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Wm B VandeGrift M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: May 13, 1965
23C. PHYSICIAN'S NAME (Type): William B. VandeGrift, M.D.
23D. ADDRESS: 1400 N. Caroline St., Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/15/65	Sacred Heart Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: MAY 14 1965
25B. NAME OF REGISTRAR: Robert E. Faherty M.D.
25C. FUNERAL DIRECTOR — ADDRESS: Schimunek Funeral Home, Inc. 3331 Brehms Lane

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-628 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5128 Registered No. 65 5128

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mrs. Elsie Elizabeth Powers

2. DATE AND HOUR OF DEATH: May 11, 1965 | 11.50 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Edgewood Nursing Home, 6000 Bellona Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 15-10
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4102 Fernhill Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Widow	April 16, 1883	82				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Millinery	Dress Shop	Maryland	U S A

13. FATHER'S NAME: Oliver Smith

14. MOTHER'S MAIDEN NAME: Elizabeth Christmas

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	213 00 8377	Mrs. Catherine M. McQuade	3325 Chestnut Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO	Carcinoma tail, abdomen	3+ mos
(B) DUE TO	Biliary duct carcinoma	6+ mos
(C)		

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 11 1965 to May 12 1965, that (I) (we) last saw the deceased alive on May 11 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
Frederick J. Vollmer		☐	☑	☐	May 13, 1965

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Frederick J. Vollmer		6100 York Rd. Baltimore 21212

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	May 15, 1965	St. Mary's (Hampden)	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 14 1965	Robert E. Farley M.D.	Burgee Funeral Home, Horace F. Burgee	3631 Falls Road

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-610 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5129 Registered No. 65 5129

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Richard F. Murphy

2. DATE AND HOUR OF DEATH May 13, 1965 8:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location) Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00
D. STREET ADDRESS (If rural, give location) 2218 Southern Rd

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Caue	Married	7-21-02	62				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Doorman		Maryland	United States

13. FATHER'S NAME Michael Murphy

14. MOTHER'S MAIDEN NAME Sara McCourt

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
unknown	218-10-1008	old chart	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of lung DUE TO
(B) DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from April 12 1965 to May 13 1965, that (I) (~~we~~) last saw the deceased alive on May 12 1965 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE				23B. DATE SIGNED
Charles T. Fletcher M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☑	May 13, 1965

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
CHARLES T. FLETCHER M.D.	UNION MEMORIAL HOSPITAL Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	5/17/65	Gardens of Faith	Balto.	Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 14 1965	Ross E. Fahey M.D.	Connelly	300 Mace Ave. Balto. 21

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

SAB-43-53-761

D-362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5130 Registered No. 65 5130

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ~~Mrs.~~ Daisy Dietrich

2. DATE AND HOUR OF DEATH 5-11-1965 3.35 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township) 53-00

D. STREET ADDRESS (If rural, give location) 930 Thompson Blvd. 21221

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widowed	4/27/80	85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at Home.		Balto,	U.S.A.

13. FATHER'S NAME Theodore H. Trouble

14. MOTHER'S MAIDEN NAME Ida M. Ruerfel

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Records: BCH	4940 Eastern Avenue 21224

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Acute Myocardial Infarction	2 hours
	DUE TO (B) Arteriosclerotic Cardiovascular Disease	? years
	DUE TO (C)	
II	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-7- 19 65 to 5-11- 19 65, that (I) (we) last saw the deceased alive on 5-11- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
J. B. Zachary,		☐	☐	☒	5-11-1965

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Dr. J.B. Zachary		4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	5/13/65	Western Cemetery	Balto.	Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 11 1965	Robert E. Farley, M.D.	Connelly	300 Mace Ave. Balto. 21

VS 150-REV. 1/1/65

1

D-565

BALTIMORE CITY HEALTH DEPARTMENT

65 5131

BIRTH NO. 65 5131

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EVERETT V. DAMRON

2. DATE AND HOUR PRONOUNCED DEAD: May 11, 1965 2:06 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): South Baltimore Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-01
D. STREET ADDRESS (If rural, give location): 46 E. Montgomery St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
male	white	Divorced	9/7/1891	73				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Chem. Co.	Nelson Co., Va.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Damron	Mattie Henderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	-	228 22 7197	Mrs. Maggie Lee	46 E. Montgomery

MEDICAL CERTIFICATION

18. 722.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECENDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Rudiger Breitenecker M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 5-12-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/15/65	Rockfish Presby. Cem.	Greenfield, Va.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 14 1965	Robert E. Farley M.D.	JOHN F. DENNY, INC.	715 Light St.

VS 151-REV. 1/1/65

S-636 1

BIRTH NO. Hanover Gen'l · Pa 65 5132

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5132

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Sourder Douglas Holliday

2. DATE AND HOUR OF DEATH: 5.10.65 | 4.05 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pennsylvania B. COUNTY: Hanover General Hospital
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Hanover V-35
D. STREET ADDRESS (If rural, give location): 100 Eichelberger Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W		4.13.65		0 / 27	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
x	x	Hanover General Hospital	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles H. Sourder Jr	Nancy Mellhorn

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no			Chart	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not meon the mode of dying, e.g., heart foilure, osthenio, etc. It means the diseose, injury or complicotion which coused deoth.)

(A) DUE TO: Congenital Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 27 days

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if ony, giving rise to the obove couse (A) stoting the UNDERLYING CONDITION lost.

(B) DUE TO:

(C):

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: operation for Congenital Heart Desease

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
5.10.65	Congenital Heart Disease		

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or about home, form, foctory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Boltimore City, give exoct locotion)

21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5.5 19 65 to 5.10 19 65, that (I) (we) last saw the deceased alive on 5.10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
Chetan Dev M.D.					5.10.65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
CHETAN DEV		University Hospital Balto Md

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/12/65	Mt. Olivet Cemetery	Hanover Pa York County

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 14 1965	Robert E. Farber M.D.	Frederick Bucher	Hanover Pa

VS 150-REV. 1/1/65

L-600 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5133 Registered No. 65 5133

1. NAME OF DECEASED (Type or Print): Alfred N. Lowry

2. DATE AND HOUR OF DEATH: 5/13/65 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddiess or locotion): 1139 Riverside Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 2402
D. STREET ADDRESS (If rural, give location): 1139 R iverside Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	Married	Aug. 22, 1901	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Koester Bakery	Rt. Salesman	Md.	

13. FATHER'S NAME: George W. Lowry

14. MOTHER'S MAIDEN NAME: Ida Stansbury

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Family	

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH
(A) Carcinoma of the lungs with metastasis to left hip — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO
(B) DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) ~~XXXXXXX~~ attended the deceased from March 1964 19 to May 11 1965, that (I) XX last saw the deceased alive on May 11 19 65 and that in(my) (XX opinion death occurred on the date and hour and from the causes stated above. (I) (We) did ~~XXX~~ XXX (do not) view the body after death.

23A. SIGNATURE: Samuel Rubin M.D. — Attending Phys. X ☐ Med. Director ☐ Staff Phys. ☐ — 23B. DATE SIGNED: 5/13/65

23C. PHYSICIAN'S NAME (Type): Samuel Rubin, M.D.

23D. ADDRESS: 203 Patapsco Avenue Baltimore, Md. 21225

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/17/65	Glen Haven Cem.	Glen Burnie, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 14 1965 Robert E. Farley, M.D		McCully Funeral Home	130 E. Fort Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-3521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5134 Registered No. 65 5134

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Ernest Stinchcomb

2. DATE AND HOUR OF DEATH: 5/13/65 | 2:30 a. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
43
South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 2401
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 513 Otterbein Street Balto. 21230, Md.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	2/20/02	63				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Electrician	B & E Co.	Md	USA

13. FATHER'S NAME: Thos. Stinchcomb

14. MOTHER'S MAIDEN NAME: Susie ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	1917 - 1921	—	Catherine Stinchcomb	- Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonia
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
—		Yes	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-27 1965 to 5/13 1965, that (I) (we) last saw the deceased alive on 5/13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Chung K. Bae M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 5/13/65
23C. PHYSICIAN'S NAME (Type): CHUNG K. BAE, M.D. M.D.
23D. ADDRESS: South Balto. Gen. Hosp. - 1213 Light St.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-17-65	Balto National Cem	Balto Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 14 1965	Robert E. Fisher, M.D.	John J. Curran & Sons, Inc.	Balto. Md

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-6001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5135 — Registered No. 65 5135

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Behr, Lawrence G.

2. DATE AND HOUR OF DEATH: May 12, 1965 — 10:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY: 26-09
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21224
D. STREET ADDRESS (If rural, give location): 3823 Hudson St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	11-30-1900	65				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Amer. Smelt & Refining	Baltimore, Maryland	U.S.A.

13. FATHER'S NAME: John Behr

14. MOTHER'S MAIDEN NAME: Kunigunda Lindberger

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	----------	212-10-1418	Myrtle M. Behr	3823 Hudson Street #24

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute myocardial infarction. — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No.	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 12, 1965 to May 12, 1965, that (I) (we) last saw the deceased alive on May 12, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ — 23B. DATE SIGNED: May 12, 1965

23C. PHYSICIAN'S NAME (Type): Anastacio E. Subong, Jr. M.D. — 23D. ADDRESS: 1400 N. Caroline St., Baltimore, Maryland 21213

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-15-65	Sacred Heart Cemetery	7401 German Hill Road Balto. 22, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 14 1965	Robert E. Fahrig	Charles L. Zeiler	904 S. Conkling Street Balto. Md. 21224

VS 150-REV. 1/1/65

1

M-240

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 65 5136 Registered No. 65 5136

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LILLIAN MOSLEY

2. DATE AND HOUR PRONOUNCED DEAD: 5-10-65 7:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): LUTHERAN HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-06
D. STREET ADDRESS (If rural, give location): 1731 Ashburton Street - 21216

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	Colored	Widowed		51				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic		Virginia	

13. FATHER'S NAME: Junious Holcomb

14. MOTHER'S MAIDEN NAME: Mabel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217-09-6884

17. INFORMANT: Mrs Junious Holcomb ADDRESS: 1004 Druid Hill Ave

MEDICAL CERTIFICATION

1B. 133.8

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of colon with anemia

DUE TO

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Peter W. Rieckert M.D.

EXAMINER'S NAME (Type): PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED: 5-10-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/13/65	Mt Calvary Cemetry	A A County Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 14 1965	Robert E. Farley M.D.	Adolphus Halstead	918 Druid Hill Ave

VS 151-REV. 1/1/65

C-516 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5137 Registered No. 65 5137

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): William A Chambers

2. DATE AND HOUR OF DEATH: May 10, 1965 3:15 a.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Stevensons Guest House

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY: 15-38
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, 16
D. STREET ADDRESS (If rural, give location): 2405 Roslyn

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	C			80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Virginia	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
?	?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	217-26-7751	Mrs Sarah Stevensn	2405 Roslyn Ave

MEDICAL CERTIFICATION

18. 4221 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not meon the mode of dying, e.g., heort foilure, osthenio, etc. It meons the disease, injury or complicotion which caused deoth.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Arteriosclerosis
DUE TO
(B) Cardio Vascular Disease 18 months
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the obave cause (A) slating the UNDERLYING CONDITION lost.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 9 1965 to May 10 1965, that (I) (we) last saw the deceased alive on May 9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	23B. DATE SIGNED
Ralph W. Redkey	Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐	5/14/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Ralph W. Redkey M.D.	426 N. Gilmor Street

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/14/65	Mt Auburn Cemetry	Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 14 1965	Robert E. Farley M.D	Adolphus Halstead	918 Druid Hill Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

15-38

15-04

80

?

?

217-26-7751 M̈s Sarah Stevenson 2405 R̈oslyn Ave

M-2531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5138 Registered No. 65 5138

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): McINTOSH, ALONZO
2. DATE AND HOUR OF DEATH: 5-11-65 | 10 17 P M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND
   FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
   A. STATE: MARYLAND B. COUNTY: 4-04
   C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
   D. STREET ADDRESS (If rural, give location): 922 NORTH BOND STREET
5. SEX: MALE
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 6-2-85
9. AGE (In years last birthday): 79 | If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Tampa, Fla.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: WUNDERS McINTOSH
14. MOTHER'S MAIDEN NAME: SARAH BOND
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Irene McIntosh ADDRESS: 922 N. Bond St.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 023 X 1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: VENTRICULAR FIBRILLATION — 10 MIN.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO: AORTIC INSUFFICIENCY — 30 YRS.

(C) LUETIC AORTITIS — 35 YRS.
ASCVD — 15 YRS

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: CARCINOMA BLADDER — 3 YRS.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from MAY 9 1965 to MAY 11 1965, that (I) (we) last saw the deceased alive on MAY 11 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Paul D. Hart M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 5-11-65
23C. PHYSICIAN'S NAME (Type): PAUL D. HART M.D.
23D. ADDRESS: JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 5/15/65
24C. NAME of CEMETERY or CREMATORY: Mt. Calvary Cem.
24D. LOCATION (City, town, or county) (State): Ann Arundel Cty. Md.

25A. DATE REC'D BY HEALTH DEPT.: MAY 14 1965
25B. NAME OF REGISTRAR: Robert E. Faulkner
25C. FUNERAL DIRECTOR: WM MARCH ADDRESS: 928 E North Ave

VS 150-REV. 1/1/65

1

C-500

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 5139

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

X 65 5139 Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) GERARD JOSEPH COMEAU				2. DATE AND HOUR PRONOUNCED DEAD May 12, 1965 12:20 p M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1101 Key Highway				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balto C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 5300 D. STREET ADDRESS (If rural, give location) 2806 Onyx Road			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5-1-1912	9. AGE (In years last birthday) 53	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CRANE OPERATOR	10B. KIND OF BUSINESS OR INDUSTRY SHIPYARD	11. BIRTHPLACE (State or foreign country) CANADA	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME NICHOLAS COMEAU		14. MOTHER'S MAIDEN NAME VICTORINE LEGER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) YES (If yes, give war or dates of service) 1930 - 1937		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Irma E. Comeau	ADDRESS 2806 Onyx Rd.			

MEDICAL CERTIFICATION

E 912.3

1B. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple traumatic injuries

DUE TO

ANTECENDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Shipyard	1101 Key Highway, Bethlehem Shipyard

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
5 12 65 9:40a.	WHILE AT WORK [X] NOT WHILE AT WORK [ ]	Crane toppled into water 24-02

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) Rudiger Breitenecker M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED 5-12-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
BURIAL	5-17-65	BALTO. NATIONAL CEM	BALTO., MD.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 14 1965	R. L. & E. Fabers	Hartley Miller	2334 Jefferson Pl.

VS 151-REV. 1/1/65

N E69.2

A-65 5 1

BIRTH NO. 65 5140

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5140

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): GEORGIE ANNA HARMAN

2. DATE AND HOUR OF DEATH: MAY 12, 1965 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): St. Joseph's Hospt.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 2701
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 5201 Hillburn

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, (WIDOWED) DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: JUNE 8, 1883
9. AGE (In years last birthday): 81
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): BALTIMORE
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Hann Reed
14. MOTHER'S MAIDEN NAME: Mary Whalen

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 217-01-8881
17. INFORMANT: Jessie Marmion ADDRESS: 5201 Hillburn Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 422.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) DUE TO: Arteriosclerotic Cardiovascular Disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(B) DUE TO:
(C):

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-10 1963 to 4-20 1965, that (I) (we) last saw the deceased alive on 4-20 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sebastian Russo M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 5/13/65
23C. PHYSICIAN'S NAME (Type): SEBASTIAN ROSSO M.D.
23D. ADDRESS: 3017 Hartford Rd

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: MAY 15, 1965
24C. NAME of CEMETERY or CREMATORY: New Cathedral Cem
24D. LOCATION (City, town, or county) (State): BALTIMORE MD.

25A. DATE REC'D BY HEALTH DEPT.: MAY 14 1965
25B. NAME OF REGISTRAR: Robert E. Faulkner M.D.
25C. FUNERAL DIRECTOR: Joseph K. Gemmill ADDRESS: 263 S Conkling St.

VS 150-REV. 1/1/65

A-536 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5141 Registered No. 65 5141

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): ANDERSON. MAGDALENE.

2. DATE AND HOUR OF DEATH: 5/11/65 10²⁰ AM | 10 20 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 46 Lutheran Hospital of Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland. B. COUNTY: 24-10
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore.
D. STREET ADDRESS (If rural, give location): 806 Richwood Ave

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	Color.	Married	8/9/1926	38		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Spartenburg, S.C.	U.S.A.

13. FATHER'S NAME: George Murphy

14. MOTHER'S MAIDEN NAME: Minnie Bates

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	219-18-0770	Edward Anderson	806 Richwood Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Carcinomaof Cervix DUE TO	
	wide spread metastasis	
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO	
	(C)	
II	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/10/ 19 65 to 5/11/ 19 65, that (I) (we) last saw the deceased alive on 10⁵ AM 5/11/ 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
S. Rajaee					5-11-65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
SOROOSH RAJAEE SOROOSH. Rajaee		LUTHERAN HOSPITAL OF Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	May 15, 65	Arbutus Memorial Pk	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 14 1965 Robert	E. Farley M.D.	Herbert E. Nutter-3035 W. North Ave

VS 150-REV. 1/1/65

1

5-642

BIRTH NO. 65 5142

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5142

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ALVON PAUL SHERLOCK	2. DATE AND HOUR PRONOUNCED DEAD May 12, 1965 4:00 p M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1512 E 29th St.	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 21218 D. STREET ADDRESS (If rural, give location) 1512 E. 29th St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days / Hours / Min.
male	white	married	OCT. 8, 1903	61	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Electrician		Pennsylvania	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Vincent Charles Sherlock	Anna Dora Henkle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	WW II	215-14-6084	Mrs. Thelma O. Sherlock	1512 E. 29th St., 21218

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not meon the mode of dying, e.g., heart failure, osthenia, etc. It meons the diseose, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECENDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I certify thot I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and thot on this bosis, deoth in my opinion resulted from: Natural couses ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) Rudiger Breitenecker M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 5-12-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
BURIAL	5-17-65	Baltimore National	Baltimore, Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 14 1965	Robert E. Farley M.D.	Wm. Cook-Brooks, Inc., 1217 St. Paul St. 21202

VS 151-REV. 1/1/65

1

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 65 5148 Registered No. 65 5148

M.E. CASE NO.

1-162

1. NAME OF DECEASED (Type or Print): PHILLIP E. JEFFERS

2. DATE AND HOUR PRONOUNCED DEAD: May 12, 1965 / May 13, 1965 — 9:45 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location): CERTIFICATE CORRECTED 5-27-65

(If in hospital or institution, give name of hospital or institution): 300 S. Fulton Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21223 19-04
D. STREET ADDRESS (If rural, give location): 300 S. Fulton Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	married	Sept. 14, 1918	46				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CARPENTER	Lewis E. Kimmel	Baltimore, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Philip G. Jeffers	Emma Gephardt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		Gladys E. Jeffers	300 S. Fulton Ave., 21223

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease. 432.1

DUE TO

ANTECENDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Noturol causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type): Charles S. Petty M.D. Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 5/13/65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
BURIAL	5-15-65	Western Cemetery	Baltimore, Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 14 1965	Robert E. Foley M.D	Wm. Cook-Brooks, Inc.,	1217 St. Paul Street

VS 151-REV. 1/1/65

Letter from M.E.'s office 5-27-65 M.H.

B6301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5141 Registered No. 65 5141

M.E. CASE NO. 109-20-91

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Burt John

2. DATE AND HOUR OF DEATH: 5-10-65 | 1630 A.M. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 5-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1105 Low St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	Negro	Widowed	04-07-93	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retire		Ala	

13. FATHER'S NAME: Tom

14. MOTHER'S MAIDEN NAME: Margaret Montgomery

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Hospital Record	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
I (A) DUE TO	CONGESTIVE HEART FAILURE	12hrs.
(B) DUE TO	? MYOCARDIAL INFARCTION	12hrs
(C)	GASTRIC CARCINOMA.	? months.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	GASTRIC CARCINOMA.	

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
5/8/65	GASTRIC CA	YES.	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from ____ 19 ____ to May 10 1965, that (I) (we) last saw the deceased alive on May 10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
J. Gregory Kane MD M.D.	Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐	May 10, '65

23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS
J. GREGORY KANE	M.D.	JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	5-15-65	Mt Auburn Cem	Balto	Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 14 1965	R. O. & E. Foley M.D.	Rayner Sanders	2176 Preston St

VS 150-REV. 1/1/65

C-636 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 - 5145 Registered No. 65 5145

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) CARTER, LLOYD

2. DATE AND HOUR OF DEATH 9:05 PM 5/12/65

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE MARYLAND B. COUNTY 3-82

C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE

D. STREET ADDRESS (If rural, give location) 26 S. EXETER ST.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
MALE	NEGRO	SEPARATED	3-15-95	70				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	None	Smithfield, VA.	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
IKE CARTER	MARGARET WATSON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
I	(A) DUE TO CARCINOMA OF STOMACH	?
	(B) DUE TO G I Bleeding	
	(C) Renal Failure	
II	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —	

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
5/9	CA Stomach	YES	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/27 19 65 to 5/12 19 65, that (I) (we) last saw the deceased alive on May 12 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
J. Gregory Kane M.D.	Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐	5/12/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
J. GREGORY KANE M.D.	

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-15-65	Mt. Calvary Cem.	Brooklyn, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 14 1965	Robert E. Farley M.D.	C. O. Wilson	1000 Brantley Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

B-255

65 5146

BALTIMORE CITY HEALTH DEPARTMENT

65 5146

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LOUIS BACHMANN (Backman)

2. DATE AND HOUR PRONOUNCED DEAD: May 12, 1965 5:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 517 N. Castle Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-05

D. STREET ADDRESS (If rural, give location): 517 N. Castle Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 1 Yr. Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.
Male	White	Single	Sept. 20/1893	71				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Upholsterer	Baltimore	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Theodore Backman	Elizabeth Schmidt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.	unknown	Mr. John E. Pfund	3710 Yoland Rd - 18

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.

DUE TO

ANTECENDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type): Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 5/13/65

23A. BURIAL, CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	May 14/65	Baltimore	Baltimore

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 14 1965	C. E. Farley, M.D.	Philip Herwig Sons	2024 Orleans St

VS 151-REV. 1/1/65

A-6551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.
M.E. CASE NO. 65 5147

Registered No. 65 5147

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Margaret C. Herman

2. DATE AND HOUR OF DEATH: May 13, 1965 | 7:30 a M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
3601 Garrison Boulevard
Apartment 2 A
Baltimore, Maryland 21215

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 15-10
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3601 Garrison Boulevard 15

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widowed	Dec. 25, 1895	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Treasurer - sponging	Frank J. Hanson, Inc.	Baltimore, Maryland	

13. FATHER'S NAME: George Himmelhaber

14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	217-34-7738	Mr. Frank J. Hanson	413 W. Pratt Street Baltimore, Md. 21201

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
1B. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary occlusion	1 hour
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	DUE TO (B)	
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Aug 19 1958 to May 13, 1965, that (I) (~~we~~) last saw the deceased alive on April 30, 1965 and that in (~~my~~) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☑	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
Abraham B. Hurwitz					May 13, 1965

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
ABRAHAM B. HURWITZ		7501 LIBERTY ROAD BALTIMORE MD.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/15/1965	Lorraine Park Mausoleum	Woodlawn, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 14 1965	Robert E. Farley M.D.	Wm J. Tickera & Son	[illegible]

VS 150-REV. 1/1/65

1

K-420

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 65 5148 Registered No. 65 5148

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ALEXANDER S. KALOZI	2. DATE AND HOUR PRONOUNCED DEAD April 28, 1965 | 8:55 P M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Baltimore City Hospitals	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 11-01; D. STREET ADDRESS (If rural, give location) 901 N. Calvert Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	5/20/1904	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic		Cleveland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Michael Kalozi	Elizabeth Kalsch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	295-10-5476	Mrs. Dawn M. Recalde Miami Shore, Florida	10495 N. E. 2nd.

MEDICAL CERTIFICATION

E8028

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Multiple Traumatic Injuries.	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO (B)	
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Railroad Yard	Bayview Yards, B&O Railroad 26-08

21D. TIME OF INJURY (APPROX.) (Month)	(Day)	(Year)	(Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
4	28	'65	P m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Pedestrian struck by train.

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Petty M.D.

EXAMINER'S NAME (Type) Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 4/29/65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/15/1965	New Cathedral Cemetery	Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 14 1965	Robert E. Tawley, M.D.	Wm. J. Tschan & Sons	Balto., Md. 21217 North & Pa. aves.

VS 151-REV. 1/1/65

N867.2

K-209 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5149 Registered No. 65 5143

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Margaret Keys

2. DATE AND HOUR OF DEATH: 5/13/65 5;00 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Bon Secour Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 20-04
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 131 S. Willard St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F.	C.	W.	2/22/1900	65				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic		Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Holland	Sarah

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Celestine Fagan	131 S. Willard St.

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: Hypertensive Cardio-
(B) DUE TO: Renal Disease
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-22 1962 to 5-13 1965 that (I) (we) last saw the deceased alive on 5-12 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Wayland E. Jones M.D. — Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐ — 23B. DATE SIGNED: 5/14/65

23C. PHYSICIAN'S NAME (Type): Wayland E. Jones M.D. — 23D. ADDRESS: 1300 N. Fremont Avenue

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/15/65	Mt. Auburn Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 14 1965	R. Lee E. Faulkner	Charles A. Rice 661 W. Barre St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

L-520

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 5150 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No. 65 5150

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ELLA ELIZABETH LINK	2. DATE AND HOUR PRONOUNCED DEAD: May 11, 1965 8:45 p M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Union Memorial	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-06 D. STREET ADDRESS (If rural, give location): 3217 The Alameda

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
female	white	Married	Aug.21,1921	43		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Dept. Store	Berkeley County, W.Va.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Frank Abshire	Emma Leona Hutton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No		Mrs. Calvin L. Donaldson	Baltimore, Md.

MEDICAL CERTIFICATION

18.	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
581.0 I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Bronchopneumonia	
	DUE TO	
ANTECENDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Fatty metamorphosis of the liver	
	DUE TO	
	(C)	
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 5-12-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5-14-65	Spring Mills Cemetery	Hedgesville, Route 1, W.Va.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 14 1965	Robert E. Farley, M.D.	H.K.Brown, Brown Funeral Home-Martinsburg, W.Va.

VS 151-REV. 1/1/65

K-530 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5151 Registered No. 65 5151

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Charles R. Kennedy, Jr.

2. DATE AND HOUR OF DEATH: 8 AM 5/12/65 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. of Md. Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland. B. COUNTY: 20-05
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 502 S. Pulaski St. (#23)

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	never married	6-3-53	11				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
~~Child~~ student	school	Balto Maryland	USA

13. FATHER'S NAME: Charles R. Kennedy

14. MOTHER'S MAIDEN NAME: June Suter

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): NO —

16. SOCIAL SECURITY NO.: NO

17. INFORMANT: CHARLES R. KENNEDY, SR. ADDRESS: FATHER - 502 S. Pulaski Street-21223

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(B) DUE TO	
	(C) Pineal gland Cyst.	13 months.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Staphylococcal bacteremia	14 days

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
5/4/65	removal of ventriculo-atrial shunt		

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
NO		

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/27/65 19 to 5/12/65 19, that (I) (we) last saw the deceased alive on 5/12/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Mitchell Carl Sollod M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED: 5/12/65.

23C. PHYSICIAN'S NAME (Type): MITCHELL CARL SOLLOD M.D. 23D. ADDRESS: UNIV OF MARYLAND HOSP. BALTO, MD

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-15-65	Lorraine Park Cemetery	Woodlawn, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 14 1965	Robert E. Farley, M.D.	Howard H. Hubbard-4107 Wilkens Ave-21229

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-235 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5152 Registered No. 65 5152

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) McDonald, Ralph M.

2. DATE AND HOUR OF DEATH May 11, 1965 | 11:25 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location) University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore City
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 2402
D. STREET ADDRESS (If rural, give location) 1309 Herkimer St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	Married, separated	July 5, 1915	49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Georgia	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James McDonald	Laura Hightower

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	WW II		Marie Taylor	1309 Herkimer Balto, Md.

MEDICAL CERTIFICATION

18. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Acute Myocardial infaction DUE TO ~~Arteriosclerosis~~ — INTERVAL BETWEEN ONSET AND DEATH: 11 hrs, 25 min

(B) Arteriosclerotic Heart Disease DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 11, 1965 19 to 19, that (I) (we) last saw the deceased alive on May 11, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
Leif I. Solberg M.D.	Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒	5/11/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Leif I. Solberg M.D.	University Hospitals

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-15-65	East View Cemetery	Aparisville, Georgia

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 14 1965	Robert E. Foley, M.D.	Howard H. Hubbard-4107 Wilkens Ave-21229

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-340 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5153 Registered No. 65 5153

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) GILBERT B LITTLE 2. DATE AND HOUR OF DEATH 5-12-65 | 1:35 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion) Church Home & Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 25-31
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 29
D. STREET ADDRESS (If rural, give location) 5013 Frederick Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	3-24-07	58				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk		Maryland	U.S.A

13. FATHER'S NAME Ephrain Little

14. MOTHER'S MAIDEN NAME Margaret Bolton

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	705-05-4965	Irma Little	5013 Frederick Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) DUE TO Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Hours.
(B) DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-12-65 19 to 5-12-65 19, that (I) (we) last saw the deceased alive on 5-12-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Cesar R. Bariso, M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED 5-12-65

23C. PHYSICIAN'S NAME (Type) CESAR R. BARISO, M.D. 23D. ADDRESS Church Home & Hospital - Balto. 31, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-14-65	Meadowridge Memorial Park	Elkridge, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 14 1965	Robert E. Yanke, M.D.	Howard H. Hubbard-4107 Wilkens Ave-21229

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-0001

BIRTH NO. (2) 65 5154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5154

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Jane E. Dew — DEW, MRS JANE E.
2. DATE AND HOUR OF DEATH: 5-13-65 7:20 PM
3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BON SECOURS Hospital
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) — A. STATE: Md. B. COUNTY: Baltimore 28-04 — C. CITY OR TOWN (If outside city limits, write RURAL and give township): 4512 MANORLENE Rd. — D. STREET ADDRESS (If rural, give location): Baltimore 29, Md.
5. SEX: F
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 5/14/1890
9. AGE (In years last birthday): 74 — If Under 1 Yr. Months / Days; If Under 24 Hrs. Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Howard Co, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: HARRY L. COLLINS
14. MOTHER'S MAIDEN NAME: IDA DIXON
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 213-10-3936
17. INFORMANT: Mrs. J. Leroy Phillips — ADDRESS: 801 Glen Allen Driv

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO: Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: Many years

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Diabetes Mellitus

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED — While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-11-65 19 to 5-13 19 65, that (I) (we) last saw the deceased alive on 5-13 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Genaida C. Palad M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 5-13-65
23C. PHYSICIAN'S NAME (Type): GENAIDA C. PALAD M.D.
23D. ADDRESS: BON SECOURS HOSP. FAYETTE & Pulaski Hwy

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: May 17/65
24C. NAME of CEMETERY or CREMATORY: Christ Episcopal Church
24D. LOCATION (City, town, or county): Howard Co. Md Guilford

25A. DATE REC'D BY HEALTH DEPT.: MAY 14 1965
25B. NAME OF REGISTRAR: Robert E. Farber, M.D.
25C. FUNERAL DIRECTOR: Wittstadt F. W. — ADDRESS: 4101 Edmondson Ave

VS 150-REV. 1/1/65

C-755 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.
M.E. CASE NO. 65 5155

Registered No. 65 5155

1. NAME OF DECEASED (Type or Print): BESSIE CASHMAN

2. DATE AND HOUR OF DEATH: 5-12-65 8:15 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: Carroll
C. CITY OR TOWN (If outside city limits, write RURAL and give township): MIDDLEBURG
D. STREET ADDRESS (If rural, give location): BROOKFIELD MANOR

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
FEMALE	WHITE	WIDOWED	12-04-80	84				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	NONE	Carroll County, Md.	U.S.A.

13. FATHER'S NAME: JOHN CLINGAN

14. MOTHER'S MAIDEN NAME: (WHITMAN) Mary Ellen Whitmore

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	219-20-2935	Mrs. Harvey Bankert	Westminster, Md. R-2

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I 1B. 570.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Respiratory Failure	immediate
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(B) DUE TO Intestinal Obstruction	2 weeks
	(C) DUE TO Mesenteric Thrombosis	2 weeks
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Arteriosclerotic heart disease	30 years

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
4-28-65	MESENTERIC OCCLUSION	No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (this hospital) attended the deceased from 4-28 1965 to 5-12 1965, that (we) last saw the deceased alive on May 12 1965 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
R. Darryl Fisher, MD	M.D.	☐	☐	☑	5-12-65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
R. DARRYL FISHER, M.D. M.D.	

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/15/65	Church Of God Cemetery	Uniontown, Carroll Co., Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 14 1965	Robert E. Fahey, M.D.	Richard A. Little	Littlestown, Pa.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-469 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5156 Registered No. 65 5156

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) MARGARET LAVINIA MILLER

2. DATE AND HOUR OF DEATH May 13, 1965 12: 30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

US Public Health Service Hospital
Wyman Pk. Drive & 31st Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md. B. COUNTY Balto

C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 5607 Piedmont Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Widow	9/25/09	55				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Balto Md.	USA

13. FATHER'S NAME Clinton Heacock

14. MOTHER'S MAIDEN NAME Bessie Nicholson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	212-26-7288	Betty J. Masimore	5607 Piedmont Ave. #7

Records XXXX

W-425 1

BIRTH NO. 65 5157

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 5157

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Dessie O. Wilson

2. DATE AND HOUR OF DEATH: May 14, 1965 | 4:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location)
6104 O'Donnell Street
Baltimore 24, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY: same address 26-05
C. CITY OR TOWN (If outside city limits, write RURAL and give township): same address
D. STREET ADDRESS (If rural, give location): same address

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
female	white	widowed	10-12-1900	64 years		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	housewife	Maryland	U.S.A.

13. FATHER'S NAME: Larry E. Porter

14. MOTHER'S MAIDEN NAME: Ruth Naylor

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	215-24-3187	Son David L. Wilson	6104 O'Donnell Street Baltimore 24, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
18. 442 X I	(A) Acute pulmonary edema	15 minutes
	DUE TO (B) left ventricular failure	3 days
	DUE TO (C) Hypertensive arteriosclerotic cardio vascular renal disease	10 +
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	generalized arteriosclerosis, Moderate; obesity, Moderate.	

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from XXXXXX 1947 19 to May 14, 19 65, that (I) (~~we~~) last saw the deceased alive on May 13, 19 65 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: R. V. Rangle M.D. — Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐ — 23B. DATE SIGNED: May 14, 1965

23C. PHYSICIAN'S NAME (Type): R. V. Rangle, M. D. M.D.

23D. ADDRESS: 2938 St. Paul Street Baltimore 18, Maryland

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/17/65	Saint Matthews Cemetery	Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 14 1965	Robert E. Farley, M.D.	Henry Sander & Sons Inc Baltimore Maryland 21213

VS 150-REV. 1/1/65

1

F-520

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 65 5158 Registered No. 65 5158

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JAMES FENWICK

2. DATE AND HOUR PRONOUNCED DEAD: May 12, 1965 | 10:15 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-03

D. STREET ADDRESS (If rural, give location): 520 Presstman Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Negro	widowed	Oct 14 1914	50				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	U.S.A.

13. FATHER'S NAME: Louis Fenwick

14. MOTHER'S MAIDEN NAME: Veronica Gough

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		Bernice Dyson	180 S Louden Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I 493X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular Disease.

DUE TO

ANTECENDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Petty M.D.

EXAMINER'S NAME (Type) Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 5/13/65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5-15-65	Mt Auburn Cem	Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 14 1965	Robert E. Faber M.D.	George A. Fuller	1349 N Calhoun St

VS 151-REV. 1/1/65

1

H-652

43

BALTIMORE CITY HEALTH DEPARTMENT

65 5159

BIRTH NO. 65 5159 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ~~LEE~~ HORNES, Leandrew

2. DATE AND HOUR PRONOUNCED DEAD: May 12, 1965 | 2:05 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-01
D. STREET ADDRESS (If rural, give location): 1637 W. North Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months / Days / Hours / Min.
Male	Negro	Married	Nov 8, 1920	44	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		N. C.	U. S. A

13. FATHER'S NAME: Charles Hornes

14. MOTHER'S MAIDEN NAME: Idaetta Horton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Maggie Hornes	1637 W. North Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. E911.3

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Crushing Injuries of Thorax and Abdomen.

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Plant

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 5600 Chemical Road 25-05

21D. TIME OF INJURY (APPROX.)	(Month)	(Day)	(Year)	(Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	5	12	'65	P m.	WHILE AT WORK [X] NOT WHILE AT WORK [ ]	Operator of Payloader which fell into pit.

22. I certify that I held on Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 5/13/65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5-16-65	Church Cem.	Portsmouth, Va.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 14 1965	Robert E. Farley, M.D.	George A. Kelso	13 E. N. Calhoun St

VS 151-REV. 1/1/65

N 8 69.2

W-107 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5160 Registered No. 65 5160

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): CRAWFORD WEBB

2. DATE AND HOUR OF DEATH: 5/12/65 | 8.45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): LUTHERAN HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY: 16-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore -17- Md.
D. STREET ADDRESS (If rural, give location): 1627 W. Mosher St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	NEGRO	DIVORCED	12/25/15	49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		N.C.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Riley Cobbs	Mrs Webb

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW II	245-01-4896	Madine Webb	1627 Mosher St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) UNCONTROLLED DIABETES MELLI-TUS.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO CEREBRO VASCULAR ACCIDENT

(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/15 19 65 to 5/12 19 65, that (I) (we) last saw the deceased alive on 5/12 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
Oscar Fernandini					5/12/65

23C. PHYSICIAN'S NAME (Type) OSCAR FERNANDINI M.D. 23D. ADDRESS Lutheran Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-17-65	Balto. Meth. Cem.	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 14 1965	R. L. & E. Farber, M.D.	George A. Kelso	1348 N. Calhoun St

VS 150-REV. 1/1/65

S-313 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5161 Registered No. 65 5161

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) STEPTOE- RAUD Maude

2. DATE AND HOUR OF DEATH 5/11/65 1.35 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI- HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE M.D. B. COUNTY 27-16
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 2814 EDGECOMBE- CIRCLE #15-

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	C-	married	1/13/16	49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Va.	U.S.A.

13. FATHER'S NAME Isaiah Smith

14. MOTHER'S MAIDEN NAME Maggie Bee

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	--	Stewart Steptoe	2814 Edgecomb Cir.

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I (33 1/X) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) CVA-	3 months
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(A) DUE TO HYPERTENSION - SEVERE	?
	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/6/65 19 to 5/11/65 19, that (I) (we) last saw the deceased alive on 5/11/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
Arch Ary M.D.	Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐	5/11/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
ARON-ARY M.D.	SINAI- HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-15-65	Church Cem.	Northumberland Co. VA.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 14 1965	Robert E. Farley M.D.	George A. Kelso	1348 N. Calhoun St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

S-530

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 5162

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5162

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): OTTO SCHMIDT

2. DATE AND HOUR PRONOUNCED DEAD: May 11, 1965 10:20 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): St. Josephs Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 2001 Cliftwood Avenue

8-15

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
male	white	Widower	Dec. 31, 1908	56				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Checker	Laundry	Baltimore Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Lawrence Schmidt	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		216 03 0264	George Flentje Jr. Attorney	401 Equitable Bldg. Balto. 2, Md

MEDICAL CERTIFICATION

E983X

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary emboli and bronchopneumonia

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B) Fracture of right hip

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Street	Rear of 2001 N. Washington St.

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
4 22 65 11:30p.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Allegedly assaulted

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [ ] Undetermined manner [X]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): K. Breitenecker M.D. Rudiger Breitenecker

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 5-12-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/15/65	Oak Lawn Cemetery	Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 14 1965	Robert E. Farley, M.D.	Henry Sander & Sons Inc. Baltimore Maryland

VS 151-REV. 1/1/65

N220.0

B-2321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65-09756 65 5163 Registered No. 65 5163

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): BABY GIRL BOSTIC
2. DATE AND HOUR OF DEATH: 4-15-65 | 11:50 P.M. M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND
   FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): MERCY HOSPITAL INC
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
   A. STATE: MD B. COUNTY: 9-04
   C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
   D. STREET ADDRESS (If rural, give location): 642 E. 29TH ST
5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): NEVER MARRIED
8. DATE OF BIRTH: 4-15-65
9. AGE (In years last birthday): If Under 1 Yr. Months / Days; If Under 24 Hrs. Hours / Min.: 10
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Eddie ARNOLD BOSTIC
14. MOTHER'S MAIDEN NAME: BETTY LOU GORMAN
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. 776X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It meons the diseose, injury or camplicotion which coused deoth.)

(A) DUE TO: Immaturity

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if ony, giving rise to the abave cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO: Incompetant cervix

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 6
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)
21B. PLACE OF INJURY (e.g., in or obout home, form, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Boltimore City, give exoct locotion)
21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-15 1965 to 4-15 1965, that (I) (we) last saw the deceased alive on 4-15 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: George H. Miller M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type): GEORGE H MILLER M.D.
23D. ADDRESS: 1013 N. CALVERT ST BALTO MD 21202

24A. BURIAL CREMATION, REMOVAL (Specify): 4-17-65
24B. DATE
24C. NAME of CEMETERY or CREMATORY: Gardens of Faith
24D. LOCATION (City, town, or county) (State): Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.: MAY 17 1965
25B. NAME OF REGISTRAR: Robert E. Fabian M.D.
25C. FUNERAL DIRECTOR ADDRESS: John A. Moran, Inc. 3000 E. Balto. St.

VS 150-REV. 1/1/65

P-200 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5164 Registered No. 14 35 69 RS

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) PACK, JAMES Edgar

2. DATE AND HOUR OF DEATH 5-14-65 9:20 AM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion)

THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MARYLAND B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE

D. STREET ADDRESS (If rural, give location) 1831 NORTH SPRING STREET

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	N	MARRIED	2-18-07	58				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retail clerk	Seafood	Maryland	U.S.A

13. FATHER'S NAME JAMES PACK

14. MOTHER'S MAIDEN NAME ELNORE EPPS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		219-01-0615	Mildred E. Pack	1831 N. Spring St.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CVA

DUE TO

(B) ASCVD

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from 4/27 1965 to 5/14/65, that (I) (we) ~~last~~ saw the deceased alive on 9:30 A.M. 4/14 1965 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE Michael Lesch M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED 5/14/65

23C. PHYSICIAN'S NAME (Type) MICHAEL LESCH M.D. 23D. ADDRESS JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-19-65	Mt. Calvary	Ann Arundel Co., Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 17 1965	Robert E. Faikeyn	1735 Harford Ave. Marshall W. Jones, Jr.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

4-208 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5165 Registered No. 65 5165

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) LULA MAY HAYES

2. DATE AND HOUR OF DEATH 5/14/65 2.00 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location) UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY 27-10
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 4722 WRENWOOD AVE.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	NEGRO	WIDOW	6/8/86	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	—	VIRGINIA	U.S.A.

13. FATHER'S NAME THOMAS MANNS

14. MOTHER'S MAIDEN NAME ELIZABETH —— MANNS.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		HOSPITAL RECORDS; MRS Dorothy Thornton	4722 Wenwood ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 450.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO	Bronchopneumonia	days
(B) DUE TO	Generalized arteriosclerosis severe	yrs
(C)	Thrombo-embolism	
2nd	right pulmonary artery	days

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		yes	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/13 19 65 to 5/14 19 65, that (I) (we) last saw the deceased alive on 5/14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
William R. Linton, Jr.					5/14/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
WILLIAM R. LINTON, JR. M.D.	UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-17-65	Arbutus Memorial	Arbutus, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 17 1965	Robert E. Farley M.D.	the Morton & Dyatt Fun'l Home Inc, 1701-31 Laurens

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

B-300

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 65 5166 Registered No. 65 5166

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LESTER BUDD

2. DATE AND HOUR PRONOUNCED DEAD: 5/14/65 4:05 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Johns Hopkins Hospital

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1219 Ellwood Ave.

B-03

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
male	colored	MAR.	Feb 14 1896	69				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Cont. Work	Carroll Co. Md.	U.S.A.

13. FATHER'S NAME: Charles Budd

14. MOTHER'S MAIDEN NAME: Mazie Arland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS: Mamie Bud - 1219 Ellwood Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchogenic carcinoma with metastases

DUE TO

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

162.1

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		no	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type): Werner U. Spitz M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED: 5/14/65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	May 18, 1965	Mt Auburn	Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 17 1965	Robert E. Farber, M.D.	Morton + Dye F. 1701 Laurens St.

VS 151-REV. 1/1/65

1-252

65 5167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. 65 5167

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): NOMAN JAYSON

2. DATE AND HOUR OF DEATH: 5/14/65 1145 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): LINCOLN MEMORIAL NURSING HOME 27N CAREY STREET BALTIMORE, MD. 21223

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 12-05
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE, MARYLAND
D. STREET ADDRESS (If rural, give location): 1702 BRENTWOOD AVE.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
MALE	Colored	Widowed	9-11-85	78				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Howard Co. Md	U.S.A.

13. FATHER'S NAME: Charles Jayson

14. MOTHER'S MAIDEN NAME: Rose Jayson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		215-16-2931	Mr. Norman Jayson Jr	640 Riverside Dr N.Y.C.

MEDICAL CERTIFICATION

18. 443X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO: Arterial Hypertension

(B) DUE TO: Cardio Vascular Disease ?

(C) Hemiplegia, left

Emphysema

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
6			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 1964 to May 14 1965, that (I) (we) last saw the deceased alive on May 13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
Wm T Johnson		☐	☐	☐	5-14-65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Wm T Johnson		403 Med Arts Bldg

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-17-65	Mount Calvary Cemetery	A. A. County, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Taylor	The Morton + Dyott Fun'l Home Inc.	1701 Laurens

VS 150-REV. 1/1/65

9-4251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5168 Registered No. 65 5168

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Poulson, Theophylus

2. DATE AND HOUR OF DEATH May 14, 1965 | 10 15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 1303
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2306 Druid Hill Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	N	MARRIED	4/2/85	80				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Va.	U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		Emma Poulson	2306 Druid Hill AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Arteriosclerotic & Vascular Heart Disease	Yrs.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 11 1965 to May 14 1965, that (I) (we) last saw the deceased alive on MAY 14 1965 and that in (my) (our) opinion death occurred an the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Leif I. Solberg M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED May 14, 1965

23C. PHYSICIAN'S NAME (Type) Leif I. Solberg M.D. 23D. ADDRESS University Hospitals

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-18-65	Arbutus Mem. Pk.	Arbutus, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Farley, M.D.	George A. Kilar	1348 N. Calhoun St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-200 1
V-252

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5169 Registered No. 65 5169

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Andrew T. (JAZHNICH) Fox

2. DATE AND HOUR OF DEATH: 5-17-65 | 7:33 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 2505
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #21226.
D. STREET ADDRESS (If rural, give location): 1414 Elmtree St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M.	W.	Married.	10-9-1913	51.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chemical Operator	Dadidson Chemical Cor	Penn.	

13. FATHER'S NAME: Anthony [redacted] (FOX) JAZHNICH

14. MOTHER'S MAIDEN NAME: Tille [redacted] Bilenki

15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes W. W. II	217-20-0541	Jennie Fox	1414 Elmtree St Zone 26

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

I
(A) Cardiac arrest
DUE TO
(B) Acute diaphragmatic myocardial infarction.
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from 5-17 1965 to 5-17 1965, that (I) (we) last saw the deceased alive on 5-17 1965, and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
Camilo C. Balacuit Jr. M.D.	☐	☐	☑	5/17/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Camilo C. Balacuit M.D. M.D.	SOUTH BALTIMORE GENERAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-20-65	Holy Cross	A, A, Co. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 18 1965	Robert E. Farber, M.D.	Wm. S. Fialkowski	2007 Eastern Ave

VS 150-REV. 1/1/65

G-125 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65-12093 65 5170 M.E. CASE NO.

Registered No. 65 5170

1. NAME OF DECEASED (Type or Print): (GIBSON, BABY GIRL) KATHERINE ANNE

2. DATE AND HOUR OF DEATH: MAY 11, 1965 5:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE 29, MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: ANNE ARUNDEL
C. CITY OR TOWN (If outside city limits, write RURAL and give township): GLEN BURNIE 21061
D. STREET ADDRESS (If rural, give location): 200 KUETHE ROAD

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
FEMALE	WHITE	NEVER MARRIED	5-11-65				1	3

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE	------	MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
DONALD C. GIBSON	PHYLLIS A. STOUT

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	X	-----	ST. AGNES RECORDS,	WILKENS & CATON AVE.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 770.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Severe Anemia with Hydrops Fetalis

(B) DUE TO: RH Incompatibility

(C)

ANTECEDENT CAUSES: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from MAY 11 19 65 to MAY 11 19 65, that (I) (we) last saw the deceased alive on MAY 11 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
Celina V.J. Guerrero		☐	☐	☑	May 11/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
GUERRERO		ST. AGNES HOSPITAL, WILKENS & CATON AVE.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/15/65	POWELL VALLEY MEM. GARDENS	BIG STONE GAP, VA.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 17 1965	Robert E. Fabian, M.D.	R.V. SINGLETON, GLEN BURNIE, MD.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-6301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5171 Registered No. 65 5171

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LENA B. SCHRADE

2. DATE AND HOUR OF DEATH: 5/13/65 7:00 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2624 WASHINGTON BLVD.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD. B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2624 WASHINGTON BLVD.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	WHITE	Widowed	August 15, 1879	85 Yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Virginia	U.S.A.

13. FATHER'S NAME: Oscar Brizdine

14. MOTHER'S MAIDEN NAME: Mary J. Fidler

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 220-05-8379

17. INFORMANT: Mrs. William Arnold, 2624 Washington Blvd. ADDRESS: 21230

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 da

(B) DUE TO: Arteria Sclerotic Cardio Vascular Disease — 10 yrs

(C):

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED White At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/10/65 19 to 5/13 19 65, that (I) (we) last saw the deceased alive on 5/13/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Joseph G Laukaitis M.D. — Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐ — 23B. DATE SIGNED: 5/13/1965

23C. PHYSICIAN'S NAME (Type): JOSEPH G. LAUKAITIS M.D. — 23D. ADDRESS: 679 WASHINGTON BLVD.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/15/65	Loudon Park Cemetery	Wilkens Avenue, Balto., City, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 1st 1965	Robert E. Farley M.D.	HOWARD H. HUBBARD	4107 WILKENS AVE. 21229

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-235 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5172 Registered No. 65 5172

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) MACDONALD LOTTE

2. DATE AND HOUR OF DEATH 5/12/65 7:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location) South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 25-42
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore # 21230.
D. STREET ADDRESS (If rural, give location) 2500 Brohawn Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F.	White.	Married.	4-18-1884.	81				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	None.	Baltimore, Md.	U.S.A.

13. FATHER'S NAME Frederick Leutner

14. MOTHER'S MAIDEN NAME Sarah Getz

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs. Flora L. Hale	2500 Brohawn Ave. 21230

MEDICAL CERTIFICATION

1B. 2607 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) HASCVD. — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

DUE TO (B) Diabetes Mellitus

DUE TO (C) Pneumonia
Paget's disease
Arteritis

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (this hospital) attended the deceased from 4-30 19 65 to 5/12 19 65, that (we) last saw the deceased alive on 5/12 19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
Chung K. Bae M.D.	☐	☐	☑	5/10/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Chung K. Bae M.D.	SOUTH BALTIMORE GENERAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/15/65	Loudon Park Cemetery	Wilkens Avenue, Balto., City, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 17 1965	Robert E. Farley M.D.	Howard H. Hubbard, 4107 Wilkens Ave. 21229

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-3221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.
M.E. CASE NO. 65 5173

Registered No. 65 5173

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): HITCHCOCK, ALBERT

2. DATE AND HOUR OF DEATH: 5-12-65 | 6 20 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location): SINAI HOSPITAL OF BALTIMORE
BALTIMORE MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 6-05
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 8 IRVING PLACE #8

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	CAUCASIAN	WIDOWER	6-20-04	60				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	BALTO. TRANSIT	MD	USA

13. FATHER'S NAME: OTIS E. HITCHCOCK

14. MOTHER'S MAIDEN NAME: SUSIE V. BECK

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	—	217-03-3253	MR CHAS AMRHINE	SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not meon the mode of dying, e.g., heart foilure, osthenio, etc. It meons the diseose, injury or complicotion which coused deoth.)

(A) MULTIPLE PULMONARY METASTASES

DUE TO

(B) CARCINOMATOSIS FROM CA OF RECTUM

DUE TO

(C) CVA —

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if ony, giving rise to the obove couse (A) stoting the UNDERLYING CONDITION lost.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
APRIL, 1965	FEEDING JEJUNOSTOMY	NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exoct locotion)

21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from MAY 12 1965 to MAY 12 1965, that (I) (we) last saw the deceased alive on MAY 12 1965 and that in(my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 5-12-65

23C. PHYSICIAN'S NAME (Type): CLARO L. PIO RODA M.D.

23D. ADDRESS: SINAI HOSPITAL OF BALTIMORE

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/15/65	DRUID RIDGE	BALTO MD #8

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Farley M.D.	J. I. STANSBURY	BALTO, MD

VS 150-REV. 1/1/65

4-520 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 5174
M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5174

1. NAME OF DECEASED (Type or Print): MRS. SARAH JANE JONES

2. DATE AND HOUR OF DEATH: May 14, 1965 | 1:40 a M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 4006 Hickory Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 13-07
D. STREET ADDRESS (If rural, give location): 4006 Hickory Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widowed	Sept. 24, 1880	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home	-	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Elie Sterner	Lydia Bailey

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	-	-	Andrew J. Jones	3723 Ridgecroft Rd. 21206

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
(A) Cardio-renal -hypertensive Ht. Disease	10yrs
DUE TO (B) Pernicious Anemia	20 yrs
DUE TO (C) Diabetes Mellitus	10yrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 1953 to May 14 1965, that (I) (We) last saw the deceased alive on May 14 1965 and that In(my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
T N Wilson		X	☐	☐	May 14, 1965

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
T.N. Wilson		617 W. 40th St

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	May 18, 1965	Druid Ridge Cemetery	Pikesville, Balto. Co., Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 17 1965	R. L. & E. Falkenhan M.D.	Burgee Funeral Home, 3631 Falls Rd, Balto. Md.
		By: Horace Burgee Jr.

VS 150-REV. 1/1/65

1

M-635

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 65 5175 Registered No. 65 5175

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOSEPH EUCLID MARTIN

2. DATE AND HOUR PRONOUNCED DEAD: May 7, 1965 8:45 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): St. Agnes Hospital

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Howard
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Savage 63-00
D. STREET ADDRESS (If rural, give location): 608 Washington Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	12/15/1885	79				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
custodian	school	Canada	USA

13. FATHER'S NAME: Simon Martin

14. MOTHER'S MAIDEN NAME: ? Bechard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Georgianna Martin ADDRESS: Savage Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

E816.1

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Traumatic Injuries.

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Street	U.S. 1, N. of Baltimore Street 19-02

21D. TIME OF INJURY (APPROX.) (Month)	(Day)	(Year)	(Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
5	7	'65	P m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Driver of auto in auto-truck collision.

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 5/8/65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5-11-65	Fort Lincoln Cem	Colmar Manor Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 17 1965	Robert E. Faulkner	DeWitt Donaldson Laurel Md

VS 151-REV. 1/1/65

N 869.2

M-26) 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5176 Registered No. 65 5176

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Florence Virginia Musgrove

2. DATE AND HOUR OF DEATH: May 13, 1965 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4304 Parkwood Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY 26-72
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4303 Parkwood Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Divorced	Dec. 29, 1884	80				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At home		Maryland	U.S.A.

13. FATHER'S NAME: John Lyons

14. MOTHER'S MAIDEN NAME: Augusta Kriet

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Miss Gertrude Linsenmeyer	4303 Parkwood Ave.

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Congestive Heart Failure — 3 weeks
DUE TO
(B) Arteriosclerotic Heart Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cystitis — 3 weeks

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from 4/26 1965 to 5/13 1965, that (I) ~~(we)~~ last saw the deceased alive on 5/4 1965 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) (~~did not~~) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☑	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
Albert B Bradley					5/14/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Albert B. Bradley		4900 Belair Road

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/17/65	New Cathedral Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Faulkner M.D.	Ullrich Funeral Home	4210 Belair Road.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-218 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65-1129665 5177 Registered No. 65 5177 4

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): John Joseph Cichorz

2. DATE AND HOUR OF DEATH: MAY 13, 1965 | 10 25 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Md. Gen. Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: md. B. COUNTY: 2-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto. # 31
D. STREET ADDRESS (If rural, give location): 1808 E. Pratt st.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
MALE	white	N B	MAY 12, 1965				16	40

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
FREDERICK Michael Cichorz	ANNA Genevieve Stella

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—	—	mother	SAme

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Atelectasis

(B) DUE TO: immaturity

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

762.5 I

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
O		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 12 19 65 to May 13 19 65, that (I) (we) last saw the deceased alive on May 13 19 65 and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
Franklin Negamie					5/13/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
M.D.	Maryland General Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/14/65	ST. STANISLAUS CEM,	6515 BOSTON ST, — BALTIMORE MD

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Parker, M.D.	George A. Weber	705 S Conn st

VS 150-REV. 1/1/65

1

R-255

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 65 5178 Registered No. 65 5178

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HENRY B. RICHMOND

2. DATE AND HOUR PRONOUNCED DEAD: 5/14/65 7:00a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 673 W. Barre St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21-01
D. STREET ADDRESS (If rural, give location): 920 S. Paca St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months / Days / Hours / Min.
male	colored		11/14/13	51	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		North Carolina	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Richmond	Elizabeth Ballard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		Norma L. Carter 710 Carroll St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. E 903.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subdural hematoma

DUE TO

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		yes	yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	yard	rear of 673 W. Barre St.

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
5 14 65 ? m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	apparently fell while drunk

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

M.D. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] ASSOCIATE MEDICAL EXAMINER [X]

DATE SIGNED 5/14/65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/17/65	Mt. Auburn	Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 17 1965	Robert E. Farber, M.D.	Charles A. Rice 661 W. Barre St.

VS 151-REV. 1/1/65

N 854.2

1

V-520

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65-08224 65 5179

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5179

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ANTHONY JONES	2. DATE AND HOUR PRONOUNCED DEAD May 14, 1965 2:30 P. M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY HOSPITAL	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 18-03 D. STREET ADDRESS (If rural, give location) 109 Hayes Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Negro		3-26-65		2			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOHN JONES	MARIE WILSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Marie Wilson	109 Hayes St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

I 320 X

(A) DUE TO Interstitial pneumonitis

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE John E. Adams M.D.

EXAMINER'S NAME (Type) John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 5-15-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/18/65	Mt. Auburn	Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Foster M.D.	Charles A. Rice	661 W. Barre St.

VS 151-REV. 1/1/65

X-532

BIRTH NO. 65-10882 65 5180 M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5180

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): XANTHOS , HELEN

2. DATE AND HOUR OF DEATH: May 10, 1965 | 2:45 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 26-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5568 Whitby Road - 21206

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Never married
8. DATE OF BIRTH: May 10, 1965
9. AGE (In years last birthday)
If Under 1 Yr. Months: Days: Hours: 2 Min.: 40
If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Xanthos
14. MOTHER'S MAIDEN NAME: Cleo Pappas

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs. George Xanthos - 5568 Whitby Rd. ADDRESS

CAUSE OF DEATH

1B. 723.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory distress; probable hyaline membrane

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) Intracranial hemorrhage ? DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 10, 1965 to May 10, 1965, that (I) (we) last saw the deceased alive on May 10, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Hector C. Mendez M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. X
23B. DATE SIGNED: May 10, 1965
23C. PHYSICIAN'S NAME (Type): Hector C. Mendez, M.D.
23D. ADDRESS: 1400 N. Caroline St., Baltimore, Md. 21213

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 5-11-65
24C. NAME of CEMETERY or CREMATORY: Greek Orthodox Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: MAY 17 1965
25B. NAME OF REGISTRAR: Robert E. Fabian
25C. FUNERAL DIRECTOR: Hartley Spiller - 2534 Jefferson St. ADDRESS

VS 150-REV. 1/1/65

D-308 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5181 Registered No. 65 5181

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Lola W. Dodd

2. DATE AND HOUR OF DEATH: May 15, 1965 | 5:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5211 Wilton Heights Ave. 21215

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: Aug 8, 1904
9. AGE (In years last birthday): 60
If Under 1 Yr. Months / Days; If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Latison Wilhelm
14. MOTHER'S MAIDEN NAME: Minnie Weller

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No / None
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Charles P. Wilhelm ADDRESS: Box 66 Kingwood, W. Va.

18. 170X 1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Duct cell carcinoma breast — INTERVAL BETWEEN ONSET AND DEATH: 7 mos
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Oct 31 19 64 to May 15 19 65, that (I) (we) last saw the deceased alive on May 15 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: C. C. Haydel Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: May 15, 65
23C. PHYSICIAN'S NAME (Type): C. C. HAYDEL, JR. M.D.
23D. ADDRESS: Sinai Hosp of Balt, Inc.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 5/18/1965
24C. NAME of CEMETERY or CREMATORY: Druid Ridge Cemetery
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

25A. DATE REC'D BY HEALTH DEPT.: MAY 17 1965
25B. NAME OF REGISTRAR: Robert E. Faulkner M.D.
25C. FUNERAL DIRECTOR: wm. J. Tichnor & Son ADDRESS: Balto. Md. 17 northern Pa.

VS 150-REV. 1/1/65

E-4221

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 5182
M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5182

1. NAME OF DECEASED (Type or Print)	2. DATE AND HOUR OF DEATH
Ellis, William Frederick	13 May 65 | 8:40 p. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

University

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: California B. COUNTY: San Diego

C. CITY OR TOWN (If outside city limits, write RURAL and give township): San Diego

D. STREET ADDRESS (If rural, give location): 833 Dentro Clare PL.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	married	5-7-09	56				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired Master Sergeant U. S. A.		Mass.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William B. Ellis	Dora Lincoln Ford

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	World War II		University Hospital Records	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO: ASCVD — INTERVAL BETWEEN ONSET AND DEATH: years

(C): Diabetes mellitus — INTERVAL BETWEEN ONSET AND DEATH: years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4 May 19 65 to 13 May 19 65, that (I) (we) last saw the deceased alive on 13 May 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
Richard P. Norgaard					13 May 65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
RICHARD P. NORGAARD		University Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	5/14/1965	Mt. Hope Cemetery	Swansea, Mass.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Talley, M.D.	Wm. J. Dickman & Sons	Balto. Md. 21217 North & Pr.

VS 150-REV. 1/1/65

SAB-43-44-50 1

F-23

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5183 Registered No. 65 5183

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Donovan C. Estes

2. DATE AND HOUR OF DEATH: 5-14-1965 8:00A.M.

CERTIFICATE CORRECTED 5-20-65

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 11-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1323 North Calvert Street 21202

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Divorced	9-10-1910	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
checker	Hotel	Virginia	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Claude M. Estes	Ethel B. Chaney

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	221-05-9026	Records: BCH-4940 Eastern Avenue	21224

MEDICAL CERTIFICATION

1B. 42080

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pneumonia due to Aspiration Pneumonia — 10 days 1 week
DUE TO

(B) Arteriosclerotic Heart Disease Cerebral Infarct — 10 days
DUE TO

(C) Cardiac Arrest — 10 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-27- 1965 to 5-14- 1965, that (I) (we) last saw the deceased alive on 5-14- 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
J. B. Zachary					5-14-1965

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Dr. J. B. Zachary M.D.	4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	5/17/65	Loudon Park	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Faber M.D.	William J. Dickner + Sons North + Payson	

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Record from Balto. City Hosp. 5-20-65 M.H.

5-530 1

BIRTH NO. 65 5184

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5184

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): SCHMIDT, WILLIAM KARL

2. DATE AND HOUR OF DEATH: May 12, 1965 | 11:30 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location)
Veterans Administration Hospital
3900 Loch Raven Boulevard
Baltimore, Maryland 21218

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 20-07
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 39 S. Morley Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	10/22/10	54		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Meat Cutter		Germany	U.S.A.

13. FATHER'S NAME: Henry Schmidt

14. MOTHER'S MAIDEN NAME: Sofia Brokade

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	12/4/44 - 3/17/49	217 01 1153	VA Hospital Records	3900 Loch Raven Blvd. Baltimore, Maryland 21218

MEDICAL CERTIFICATION

420.1 + 002.1

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Thrombosis of right Coronary Artery — INTERVAL BETWEEN ONSET AND DEATH: several Hours

DUE TO

(B) Arteriosclerotic & Hypertensive Heart Disease — 10 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Tuberculosis, Pulmonary, Moderately Advanced 4 years

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from December 16th 19 64 to May 12th 19 65, that (I) (we) last saw the deceased alive on May 12th 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
Kenneth N. Payne M.D.					May 12, 1965

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
KENNETH N. PAYNE	Veterans Administration Hospital 3900 Loch Raven Blvd., Balto., Md 21218

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/17/1965	Baltimore National Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Faherty	Williams Funeral Home	319 N. Schroeder St. Baltimore, Maryland 21223

VS 150-REV. 1/1/65

4-524 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5185 Registered No. 65 5185

1. NAME OF DECEASED (Type or Print): SAMUEL YANKELEVITZ

2. DATE AND HOUR OF DEATH: MAY 15, 1965 5:30 a.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 90 BELVEDERE NURSING HOME 2525 W BELVEDERE AVE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 15-13
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2801 SANTA FE AVENUE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
MALE	WHITE	WIDOWED	11/19/1879	85				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED	TAILOR	RUSSIA	USA

13. FATHER'S NAME: KENNETH YANKELEVITZ

14. MOTHER'S MAIDEN NAME: BELLA ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	214-05-6247	MRS. TILLIE PIERCE	6705 CHISHOLM DRIVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
I	443X	
(A)	Vasomotor collapse	Several days
DUE TO (B)	Hypertension + Arteriosclerotic Cardio Vascular disease with left hemiplegia	years
(C)		
II	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from June 1954 to May 1965, that (I) (we) last saw the deceased alive on May 7, 1965 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death. May 15, 1965

23A. SIGNATURE: Louis R. Maser M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐ 23B. DATE SIGNED: 5/15/65

23C. PHYSICIAN'S NAME (Type): DR. LOUIS MASER M.D. 23D. ADDRESS: 2724 SMITH AVENUE

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
REMOVAL & BURIAL	5/16/65	EAST GATE CEMETERY	CUMBERLAND, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 17 1965	Robert E. Farley M.D.	SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-1651

BIRTH NO. 65 5186

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5186

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Robert Abrams

2. DATE AND HOUR OF DEATH: 5/14/65 12 45 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 42 SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: BALTIMORE CITY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE CITY 22-17
D. STREET ADDRESS (If rural, give location): 3008 W. GARRISON AVE.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	WHITE	MARRIED	7-7-1904	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SALESMAN	D. Bloom Assc. New York	Russia	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Issac Abrams	Sarah ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	216-09-0724	~~2~~ 1 Daughter	3008 W. Garrison Ave

CAUSE OF DEATH

	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
1B. 420.1 I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) DUE TO: Myocardial Infarction	2-3 HRS
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(B) DUE TO: Arteriosclerotic Cardiovascular Disease	
	(C)	
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

MEDICAL CERTIFICATION

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 5/14/65 2:10 PM 19 to 5/14/65 2:45 PM 19, that ~~(I)~~ (we) last saw the deceased alive on 5/14/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) (did ~~not~~) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
Melvin J. Kordon		☐	☐	☒	5/14/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
M. J. KORDON		Sinai Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/16/65	Shomrei Mishmoro	Rosedale, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Faber, M.D.	Sol Levinson & Bros Inc.	6010 Reisterstown Rd.

VS 150-REV. 1/1/65

F-646 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5187 Registered No. 65 5187

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) MRS. Rose FRailER

2. DATE AND HOUR OF DEATH 5/11/65 7:00A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location) Church Home & Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY 25-04
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 3810 2nd St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	MaRRied	10/11/88	76				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Mary land	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
GeoRGe Schroth	MaRgaRet WengaRT

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	None	Mr. John Frailer, 3810 Second St. (25)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Congestive Heart Failure — 2 days

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from 5/9 1965 to 5/11 1965, that ~~I~~ (we) last saw the deceased alive on 5/11 1965 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) (~~did not~~) view the body after death.

23A. SIGNATURE [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED 5/11/65

23C. PHYSICIAN'S NAME (Type) John J. Conroy M.D. 23D. ADDRESS Church Home & Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	May 14, 1965	Glen Haven Cemetery	Ritchie Hgwy., A.A.Co., Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 17 1965	Robert E. Farley M.D.	George J. Gonce 4001 Ritchie Hgwy. Baltimore 25, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-288 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5188 Registered No. 65 5188

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Annabelle Rush.

2. DATE AND HOUR OF DEATH: 5-13-65. 6:42 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): South Baltimore General Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Pasadena, (Greenhaven)
D. STREET ADDRESS (If rural, give location): 20-4th. St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F.	White	Married.	8-14-1901	63.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Homemaker	Housewife.	Maryland.	U.S.A.

13. FATHER'S NAME: Gutlick.

14. MOTHER'S MAIDEN NAME: Regina Wroton

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	None	Harry C. Rush.	Same as 4

MEDICAL CERTIFICATION

18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not meon the mode of dying, e.g., heart foilure, osthenio, etc. It meons the diseose, injury or complicotion which coused deoth.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: Myocardial Infarction

(B) DUE TO: Arteriosclerotic Cardiovascular Disease. 7 yrs

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if ony, giving rise to the above couse (A) stoting the UNDERLYING CONDITION lost.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No.	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that ~~it~~ (this haspitol) ottended the deceosed from 4-27 1963 to 5-11 1965; thot ~~it~~ (we) last sow the deceased alive on 5-11- 1965 ond thot in ~~my~~ (our) opinion deoth occurred on the dote ond hour ond from the couses stated obove. (I) (We) (did) (did not) view the body ofter deoth.

23A. SIGNATURE: Kermit Bonovich M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ — 23B. DATE SIGNED: 5-13-65.

23C. PHYSICIAN'S NAME (Type): Kermit Bonovich, M. D. M.D.

23D. ADDRESS: South Baltimore General Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/17/65	Glen Haven Memorial Pk	Glen Burnie Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Farley M.D.	Singleton Funeral Home	Glen Burnie

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-320 1

BIRTH NO. 60-27557 65 5189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5189

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): C. DAWN MATTHEWS	2. DATE AND HOUR OF DEATH: MAY 13, 1965 — 5:20 P.M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): ST. AGNES HOSPITAL, WILKENS & CATON AVENUE, BALTIMORE 29, MARYLAND	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: MARYLAND; B. COUNTY: Aa; C. CITY OR TOWN (If outside city limits, write RURAL and give township): GLEN BURNIE; D. STREET ADDRESS (If rural, give location): 122 LOUISE TERRACE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
FEMALE	WHITE	NEVER MARRIED	9-23-60	4				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CHILD	--------	MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
AVERY Z. MATTHEWS	JEANNE (MOODY)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — ADDRESS
NO	------	ST. AGNES HOSPITAL, WILKENS & CATON AVE.

MEDICAL CERTIFICATION

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
1B. 082.31	(A) DUE TO: Encephalitis post Viral	6 days
	(B) DUE TO: R.U.L. Upper Lobe Pneumonia	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from MAY 7 19 65 to MAY 13 19 65, that (I) (we) last saw the deceased alive on MAY 13 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
Jo'L Rubin					5/14/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
		ST. AGNES HOSPITAL, WILKENS & CATON AVE

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-17-1965	Glen Haven Memorial Pk.	Glen Burnie md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR — ADDRESS
MAY 17 1965	Robert E. Farley M.D.	Robert Pearce, Singleton Funeral Home - Glen Burnie, md.

VS 150-REV. 1/1/65

D-120 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65-12230 65 5190 X Registered No. 65 5190

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): DAVIS, BABY GIRL

2. DATE AND HOUR OF DEATH: 5/13/65 11 50 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: AA
C. CITY OR TOWN (If outside city limits, write RURAL and give township): HANOVER
D. STREET ADDRESS (If rural, give location): BOX 51 DORSEY ROAD

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	C	NEVER MARRIED	5-12-65				36	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME: CHRISTINE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
1B. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) DUE TO: Prematurity	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(B) DUE TO:	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		YES	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 12 19 65 to May 13 19 65, that (I) (we) last saw the deceased alive on May 13 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☐	House Staff	23B. DATE SIGNED
Norman Fost						5/13/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
NORMAN FOST		JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
CREMATION	5-14-65	JOHNS HOPKINS HOSPITAL	BALTIMORE, 5, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 17 1965	Robert E. Fankey M.D.	

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT 65 5190 RS 5/13/65

This certificate must be approved by the chief medical examiner or his associate, if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the disease or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CONFIDENTIAL
CAVIAR Data Sheet
Do Not File

-2
CBH

W-0001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5191 Registered No. 65 5191

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): WAH TOM W. (TOM WAI WAH)

2. DATE AND HOUR OF DEATH: May 11, 1965. 8:20 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 46 Lutheran Hospital of Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 5-10
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3318 Wyndale ave (16)

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	CHINESE	MARRIED	Aug. 26, 1890	74.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired - Mgr.	Noodle Mfg. Plant	Canton, China	Yes-USA

13. FATHER'S NAME: NOT KNOWN

14. MOTHER'S MAIDEN NAME: NOT KNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: Son	ADDRESS
NO	213-34-2422	Mr. Tom Pon	3216 Belair Rd., City

MEDICAL CERTIFICATION

1B. 260X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO: Cerebral Thrombosis c Lt. Hemiplegia.

(B) DUE TO: Hypertensive vascular disease

(C) Diabetes mellitus.

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from April 30 1965 to May 11 1965, that (I) (we) last saw the deceased alive on May 11 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☑	23B. DATE SIGNED
Joon Sueck Lee					May 11, 1965.

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Joon Sueck Lee		Lutheran Hospital of Md.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/17/65	Lorraine Park Cemetery	Woodlawn, Balto. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Tawney	Stewart & Mowen Co.,	108 W. North Ave., City

VS 150-REV. 1/1/65

5-300 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5192 Registered No. 65 5192

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) SCHOTT. ADELINE B.

2. DATE AND HOUR OF DEATH 5/16/65 12 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location)
46 Lutheran Hosp. of Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland. B. COUNTY 27-16
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore.
D. STREET ADDRESS (If rural, give location) 4750 PARK HGTS Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	white	Widow	5/13-81	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: Rebecca Harris

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	E Aurelia. DAU	4750 Park Heights Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I 156.1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not meon the mode of dying, e.g., heart failure, osthenio, etc. It meons the diseose, injury or complicolion which coused deoth.)
(A) Carcinoma of Liver DUE TO
(B) DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if ony, giving rise to the above couse (A) stoting the UNDERLYING CONDITION lost.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
O			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/13-65 19 to 5/16/ 19 65, that (I) (we) last saw the deceased alive on 11:55 AM 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE S. Rajaee M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED 5/16/65

23C. PHYSICIAN'S NAME (Type) SoRoosh Rajaee M.D. 23D. ADDRESS Lutheran Hospital of Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/19/65	Lorraine Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Fabe, M.D.	C. Vernon Lemmon	4611 Park Heights Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5193 Registered No. 65 5193

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Myrea, Eaton X

2. DATE AND HOUR OF DEATH: May 13-1965 | 1:15 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, 53-00
D. STREET ADDRESS (If rural, give location): 7208 Bridgewood Drive 21222

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	M	5/19/20	44				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tractor Operator,	Beth. Steel Co.	Virginia	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Walter Williams	Louise Dean

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	217-14-6002	Husband, Jack Eaton, # 4,a,b,c,d.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not meon the mode of dying, e.g., heort foilure, osthenio, etc. It meons the diseose, injury or complication which coused deoth.)
(A) Carcinomatosis. DUE TO
INTERVAL BETWEEN ONSET AND DEATH: Ca 2 years.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if ony, giving rise to the obove cause (A) stoting the UNDERLYING CONDITION lost.
(B) DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical exominer)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Apr. 17 19 65 to May 13 19 65, that (I) (we) last saw the deceased alive on 1 PM May 13 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
Kyoungho M. Cynn					May 13, 65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
KYOUNGHO M. CYNN		Md. General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Entombment	May 17- 1965	Lorraine Park	Dogwood Rd. Woodlawn, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 17 1965	Robert E. Farley, M.D.	JOHN J. DUDA 7922 Wise Ave. Dundalk, Md.

VS 150-REV. 1/1/65

S-4621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5194 Registered No. 65 5194

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): LOUISE SELLERS

2. DATE AND HOUR OF DEATH: 5-11-65 9:55 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 23-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1015 Peach Street Balto. 21230, Md.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	(If Under 1 Yr. Months / Days)	(If Under 24 Hrs. Hours / Min.)
Female	Colored	W.	2/3/02	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Tom Watson

14. MOTHER'S MAIDEN NAME: Mabel

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. I a

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH
(A) DUE TO: Carcinoma of the stomach with Generalize carcinoma
(B) DUE TO: Metastases.
(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
5/10/65	Carcinoma of the stomach	No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from 4-26- 1965 to 5-11 1965, that (I) (we) last saw the deceased alive on 5-11 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
[signature], M.D.		☐	☐	☑	5/11/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
ESTEBAN G. FRIERA		1213 Light St. Balto 30 Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/15/65	Mt Auburn Cem	Balt City

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Faber M.D.	Isaac L. Brown & Son	1084 N. Monroe St.

VS 150-REV. 1/1/65

H220 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5195 — Registered No. 65 5195

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined couse; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendence on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): HELEN Hughes
2. DATE AND HOUR OF DEATH: May 14, 1965 — 8:30 P.M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Hospital for The Women of Md.
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) — A. STATE: Maryland — B. COUNTY: Baltimore — C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore — D. STREET ADDRESS (If rural, give location): 1209 Argyle Ave. — 17-02

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	Negro	Married	12/9/33	31		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife		Maryland	U.S.A.

13. FATHER'S NAME: Melvin Henson
14. MOTHER'S MAIDEN NAME: Mc Nair

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Patient's Chart	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

I — 685.X

(A) DUE TO: Eclampsia, post-partum — INTERVAL BETWEEN ONSET AND DEATH: 7½ hrs.

(B) DUE TO:

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED — While At Work ☐ — Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-12 19 64 to 5-14 19 65, that (I) (we) last saw the deceased alive on 5-14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Clifton C. Presser, M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ — 23B. DATE SIGNED: 5-14-65

23C. PHYSICIAN'S NAME (Type) M.D. — 23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/18/65	Mt. Auburn	Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Farley M.D.	Irvin F. Carroll	2400 Lake Ave.

VS 150-REV. 1/1/65

C 540 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5196 Registered No. 65 5196

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Henry G Connelly

2. DATE AND HOUR OF DEATH 5/14/65 3:05 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion) University 38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Balt
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-10
D. STREET ADDRESS (If rurol, give locotion) 6407 Liberty Rd.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In yeors lost birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	white	Married	10/17/95	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Oil Salesman		Tenn.	USA.

13. FATHER'S NAME Mark S. Connelly

14. MOTHER'S MAIDEN NAME Mary Cahill

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	212-20-7331	Grace A Connelly	Same

MEDICAL CERTIFICATION

18. 420.1 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO Pulmonary edema

(B) DUE TO Myocardial Infarction - suspected

(C) recent, and documented within 2 no.

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASCVD.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		YES	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/13 1965 to 5/14 1965, that (I) (we) last saw the deceased alive on 5/14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☑	23B. DATE SIGNED
Jonathan Turek					5/14/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Jonathan Turek		University Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/18/65	Woodlawn Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Farley M.D.	Ellsworth Armacost	4600 Liberty Heights

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H200 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5197 Registered No. 65 5197

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) EDWIN FRANCIS HISKY

2. DATE AND HOUR OF DEATH 5-15-65 2 25 a.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4 Hospital for the Women of Md

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. 53 70
D. STREET ADDRESS (If rural, give location) 5425 MONTBEL AVE.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	8-14-13	51		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman ~~Woxxx~~	~~xxxxxx~~	VA.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOSEPH HISKY	TAYLOR

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes Army WW 2	213-05-520	~~Helen~~ N. Hisky	5425 Montbel Avenue

MEDICAL CERTIFICATION

1B. 13 27 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Ca of the Pancreas
DUE TO
(B) with carcinomatosis,
DUE TO
(C) generalized

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-13 19 65 to 5-15 19 65, that (I) (we) last saw the deceased alive on 5-15 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Diadema B. Amon, M.D. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED 5-15-65

23C. PHYSICIAN'S NAME (Type) M.D. 23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/19/65	Lorraine Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Farley M.D.	Ellsworth Armacost	Ellsworth Armacost 4600 Liberty Heights

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F 500 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5198 Registered No. 65 5198

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): FEENEY, MARY, ELIZABETH

2. DATE AND HOUR OF DEATH: 5-16-65 5:30A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 28-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 7
D. STREET ADDRESS (If rural, give location): 2622 GWYNNDALE AVE.

40

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	WHITE	MARRIED	3-17-06	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE		NEW JERSEY	U.S.A.

13. FATHER'S NAME: DAVID WESLEY

14. MOTHER'S MAIDEN NAME: NANCY JOHNSON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
UNKNOWN	Yes	ST. AGNES HOSPITAL	WILKENS & CATON AVE. 21229

MEDICAL CERTIFICATION

1B. 175.01

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO: Carcinoma of ovaries with multiple intra-abdominal metastases — INTERVAL BETWEEN ONSET AND DEATH: About 6 months.

(B) DUE TO:

(C):

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-20 1965 to 5-16 1965, that (I) (we) last saw the deceased alive on 5-16- 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Pablo J. Diaz M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ — 23B. DATE SIGNED: 5/16/65

23C. PHYSICIAN'S NAME (Type): DR. ARTHUR HALL M.D.

23D. ADDRESS: XX.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/19/65	Lakeview Cemetery	Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 17 1965	Robert E. Farley MD	Ellsworth Armacost 4600 Liberty Heights

VS 150-REV. 1/1/65

1

C 534

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 65 5199 Registered No. 65 5199

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HENRY CHANDLER

2. DATE AND HOUR PRONOUNCED DEAD: May 11, 1965 8:20 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 18-07
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 112 N. Schroeder St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
male	colored	Separated	5/11/	63				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		N Carolina	

13. FATHER'S NAME: Luther

14. MOTHER'S MAIDEN NAME: Hattie McAdoo

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			MRs Hattie Mc Adoo	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

E981X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gun shot wound of chest

DUE TO

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Street	110 N. Schroeder St.

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
5 11 65 8:00 p m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Shot during altercation

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Rudiger Breitenecker M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 5-12-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/17/65	Mt. Calvary Cemetry	A A County Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Farley M.D.	Adolphus Halstead	918 Druid Hill Ave

VS 151-REV. 1/1/65

N8254

1

W 252

65 5200

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

Registered No. 65 5200

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GEORGE WASHINGTON

2. DATE AND HOUR PRONOUNCED DEAD: May 12, 1965 | 1:05 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 16-02

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1419 Mosher St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
male	colored	Divorced		54				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Construction	Virginia	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Robert Washington	Blanche

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	224-07-0457	Mr Arthur Washington	1826 Penn Ave

MEDICAL CERTIFICATION

443X

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease

DUE TO

ANTECENDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 5-12-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/17/65	Mt. Calvary Cemetry	A A County Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Farley M.D.	Adolphus Halstead	918 Druid Hill Ave

VS 151-REV. 1/1/65

M1460 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5201 Registered No. 65 5201

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Hattie Miller

2. DATE AND HOUR OF DEATH: May 13, 1965 | 6:30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location): 1410 McCulloh Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 14-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1410 McCulloh St

5. SEX: Female
6. RACE: Colored
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: May 18, 1885
9. AGE (In years last birthday): 99
If Under 1 Yr. Months / Days; If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Junius Combs Whitmore
14. MOTHER'S MAIDEN NAME: Whitmore Laura Hoet

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 215-32-3090
17. INFORMANT: Nursing Home Records ADDRESS: 1410 McCulloh St.

CAUSE OF DEATH

18. 420.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO: Arteriosclerotic Heart Disease — 1 yr.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-12-64 19 to 5-13 1965, that (I) (we) last saw the deceased alive on 5-13-64 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: G. Frank Phillips M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 5/17/65
23C. PHYSICIAN'S NAME (Type): G. Franklin Phillips M.D.
23D. ADDRESS: 548 McMechen St Baltimore Md

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: May 17, 1965
24C. NAME of CEMETERY or CREMATORY: Mt Auburn Cem
24D. LOCATION (City, town, or county) (State): Westport (Balto) Md

25A. DATE REC'D BY HEALTH DEPT.: MAY 17 1965
25B. NAME OF REGISTRAR: Robert E. Fisher
25C. FUNERAL DIRECTOR: Joseph L. Kruse ADDRESS: 2222 N. Monroe Ave, Baltimore, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

5-316

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 65 5202 Registered No. 65 5202

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WILDA M. STAFFORD

2. DATE AND HOUR PRONOUNCED DEAD: 5/13/65 11:45 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Hopkins Hospital

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-07
D. STREET ADDRESS (If rural, give location): 1101 N. Broadway

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 1 Yr. Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.
female	colored		Feb 12 - 1925	40				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
			U.S.A.

13. FATHER'S NAME: Oree C. Stafford

14. MOTHER'S MAIDEN NAME: Bertie Mae Payton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.		Mame Mister	Bruce St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized septicemia complicating ~~XXXX~~ purulent proctitis and perirectal cellulitis — INTERVAL BETWEEN ONSET AND DEATH

ANTECENDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		yes	yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒

ACTUAL SIGNATURE EXAMINER'S NAME (Type): Werner M. Spitz M.D. W.M. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED: 5/14/65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5-18-1965	Cambridge Cem.	Cambridge Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Farley M.D.	Elroy O. Wilson	1001 Brantley Ave

VS 151-REV. 1/1/65

5-530 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5203 Registered No. 65 5203

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): MARIE, C. SMITH

2. DATE AND HOUR OF DEATH: 5. 16, 65 | 12 05 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): CHURCH HOME AND HOSPITAL. BALTIMORE.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD. B. COUNTY: 26-05
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE.
D. STREET ADDRESS (If rural, give location): 3433 E. Baltimore Street.

35

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W.	Married.	8. 3. 03.	61				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		MD.	U.S.A.

13. FATHER'S NAME: George Lang.

14. MOTHER'S MAIDEN NAME: Mary Horstschneider.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	214 18 7273.	Mr. William H. Smith	3433 E. Balto. St

MEDICAL CERTIFICATION

1B. 153.81

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not meon the mode of dying, e.g., heart foilure, asthenio, etc. It meons the diseose, injury or complication which caused death.)

(A) DUE TO: Metastatic Ca. of Liver, lungs.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if ony, giving rise to the obove couse (A) stoting the UNDERLYING CONDITION last.

(B) DUE TO: Ca. of Colon.

(C)

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO.	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)

21B. PLACE OF INJURY (e.g., in or about home, form, foctory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exoct locotion)

21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4. 24. 1965 to 5. 16. 1965, thot (I) (we) last saw the deceased alive on 5. 16. 1965 and thot in (my) (our) opinion death occurred on the date and hour ond from the causes stoted above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Basu M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type): Dr. N. BASU. M.D.

23D. ADDRESS: Church Home & Hospital. Balti.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/20/65	Holy Redeemer Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: MAY 17 1965 25B. NAME OF REGISTRAR: Robert E. Tabor, M.D.

25C. FUNERAL DIRECTOR ADDRESS: John A. Moran, Inc. 3000 E. Balto. St

VS 150-REV. 1/1/65

B-25 1

BIRTH NO. 65 5204
M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5204

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Bussman, Lillian

2. DATE AND HOUR OF DEATH: May 13, 1965 — 2:30 p M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore Co. 1-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #24
D. STREET ADDRESS (If rural, give location): 118 S. Ellwood Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Married	3/13/95	70				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Maryland	

13. FATHER'S NAME: John J. Simmons

14. MOTHER'S MAIDEN NAME: Margaret Joyce

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	6		Mr. Charles P. Bussman	118 S. Ellwood Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic Carcinoma (Terminal) — DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) — DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from May 7 1965 to May 13 1965, that (I) (we) last saw the deceased alive on May 13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
Salvador Marse, M.D.	M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒	May 13, 1965

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Salvador Marse, M.D.	

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/17/65	Oak Lawn Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Farley, M.D.	John A. Moran, Inc.	3000 E. Balto. St.

VS 150-REV. 1/1/65

1

B-550

65 52053

65 65205

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARSHALL J. BOHANNAN

2. DATE AND HOUR PRONOUNCED DEAD: 5/14/65 8:40 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-10
D. STREET ADDRESS (If rural, give location): 713 Belgian Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months / Days / Hours / Min.
male	white	Widower	1/8/1895	70	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Electrical Engineer	Baltimore Transit	Baltimore, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
? Bohannan	Nannie Hensley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	213-05-9012	Mrs. Marian Berlinicke	394 E. 31st St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		no	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type): Werner U. Spitz M.D. Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED: 5/14/65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/17/1965	Mount Olivet Cemetery	Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Farley M.D.	John A. Moran Inc.	3000 E. Baltimore St.

VS 151-REV. 1/1/65

H-635 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.
M.E. CASE NO. 65 5206

Registered No. 65 5206

1. NAME OF DECEASED (Type or Print): Maude I. Hartnett

2. DATE AND HOUR OF DEATH: May 14, 1965. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 1321 E. Belvedere Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 27-38
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1321 E. Belvedere Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widow	Sept. 9, 1886.	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Virginia	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jessie Parker	Isabelle Overby

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Miss Myrtle Meyer	(Same)

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Arteriosclerotic Cardio-Vascular Disease with Cardiac Decompensation	7 yrs.
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO	
	(C)	
II	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cerebral Vascular Accident	4 yrs.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 2-00 1946 to May 14 1965, that (I) (~~we~~) last saw the deceased alive on 11 May 1965 and that In (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
Wm. H. Kammer Jr. M.D.	Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐	15 May 1965

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
William H. Kammer Jr. M.D.	6011 York Rd. Balto. Md. 21212

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/19/65.	Baltimore National Cem.	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 17 1965	Robert E. Fabe, M.D.	Leonard J. Ruck Inc. Balto. 14, Md.

VS 150-REV. 1/1/65

W-2301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5207 Registered No. 65 5207

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EUGENE L. WEST, Sr.

2. DATE AND HOUR OF DEATH: 5-14-65 | 10 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 34
D. STREET ADDRESS (If rural, give location): 8304 Harford Road

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
male	white	widowed	Jan. 7, 1895	70				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Salesman		Maryland	USA

13. FATHER'S NAME: Eugene Philip West

14. MOTHER'S MAIDEN NAME: Amelia Worthman

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	282054721	Robert C. West	3011 Oakcrest Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 4 5 5 X 1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO	Septicaemia	3 days
(B) DUE TO	Bilateral Bronchial pneumonia	3 days.
(C)	Chronic Gastric Ulcer, gangrene of foot	

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
5-15-65	Gangrene	Yes	YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPRDX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-13-65 19 to 5-14-65 19, that (I) (we) last saw the deceased alive on 5-14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Terry S Shelton M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED: 5-15-65

23C. PHYSICIAN'S NAME (Type): Terry S. Shelton M.D. 23D. ADDRESS: Mercy Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	5-18-65	Holy Redeemer Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 17 1965	Robert E. Foley, M.D.	Leonard J. Ruck Inc Baltimore, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-416 1

BIRTH NO. 65 5208 M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X Registered No. 65 5208

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

40

1. NAME OF DECEASED (Type or Print): COLBERT, BESSIE ~~MAK~~ Mae

2. DATE AND HOUR OF DEATH: 5-15-65 | 7:30 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location): ST. AGNES HOSPITAL BALTO. 29, MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 5300
D. STREET ADDRESS (If rural, give location): 2104 N ROLLING ROAD

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	WHITE	WIDOWED	5-20-91	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE		PA.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
ALVERT C. MCGILL (DEC'D)	JENNIE HILL (DEC'D)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	216 36 9348	ST. AGNES HOSPITAL RECORDS	BALTO. 29

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 5-61.4 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: bilateral Bronchopneumonia + atelectasis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO: empyema left lung

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
3	Diaphragmatic hernia	YES	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that X (this hospital) attended the deceased from 5-2- 19 65 to 5-15 19 65, that X (we) last saw the deceased alive on 5-15 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X (We) (did) XXXX) view the body after death.

23A. SIGNATURE: R Ramnath M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. X

23B. DATE SIGNED: 5/16/65

23C. PHYSICIAN'S NAME (Type): RAMCHANDRA RAMNATH M.D.

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	5-19-65	Parkwood Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Foster, M.D.	Leonard J. Ruck Inc	

VS 150-REV. 1/1/65

Date of operation 5/11/65 - Informera phone
from St. Agnes Hosp. JC.

1

R-455

65 5209

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5209

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): W. Barry Poehlman

2. DATE AND HOUR PRONOUNCED DEAD: May 16, 1965 4:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Anne Arundel

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Linthicum Heights

D. STREET ADDRESS (If rural, give location): 102 Short Cross Road

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	5/20/1934	30				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Electronic Engr.	Westinghouse	Balto., Md.	U.S.A.

13. FATHER'S NAME: Edmund F. Poehlman, Sr.

14. MOTHER'S MAIDEN NAME: Sara E. Roush

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 215328985

17. INFORMANT: Mrs. Ann L Stokes Jung ADDRESS: 6612 Fair Oaks, Balto., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

E970.5

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Overdose of Doriden

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Home	102 Short Cross Road

21D. TIME OF INJURY (APPROX.)	(Month)	(Day)	(Year)	(Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
Between	5	12	65	p.m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Ingested Doriden
	5	13	65	A. m.		

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Noturol causes [ ] Accident [ ] Suicide [X] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: John E. Adams M.D.

EXAMINER'S NAME (Type): John E. Adams, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: May 16, 1965

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/19/65	Moreland Memorial Cemetery, Balto., Md.	

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Farley M.D.	Leonard J. Ruck, Inc.	Balto., Md. 21214

VS 151-REV. 1/1/65

N 974.0

V-230 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.
M.E. CASE NO. 65 5210

Registered No. 65 5210

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Zora May Vogt

2. DATE AND HOUR OF DEATH: May 14, 1965. 5:30 p.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 3714 The Alameda

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 903
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3714 The Alameda

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	widowed	9-10-1881	83				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Penna.	USA

13. FATHER'S NAME: Joseph Johnson

14. MOTHER'S MAIDEN NAME: Alberta Metcalfe

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		Mrs Edith E. Young	same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
1B. 331X I		
(A) DUE TO	Cerebral haemorrhage	48 hours
(B) DUE TO	Cerebral arteriosclerosis	Several years
(C)		

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (~~this hospital~~) attended the deceased from May 14 1965 to MAY 14 1965, that (I) (~~we~~) last saw the deceased alive on MAY 14 1965 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
Edwin Berstock M.D.	Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐	MAY. 14/65.

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
EDWIN JACK BERSTOCK M.D.	3500 N. CALVERT ST. BALTO. MD

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	5-17-65	Parkwood Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 17 1965	Robert E. Fabe, M.D.	Leonard J. Ruck Inc. Balto. 14 Md.

VS 150-REV. 1/1/65

W-620 1

BIRTH NO. (3) 65 5211 M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5211

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Clara E. Weyrich

2. DATE AND HOUR OF DEATH: May 15/65 7:30 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 3314 Edmondson Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3314 Edmondson Ave

16-28

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED (WIDOWED, DIVORCED (specify))	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Married	Aug. 15, 1885	79				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
H.W.	Own Home	Balto. Md.	USA

13. FATHER'S NAME: Jacob Brunner

14. MOTHER'S MAIDEN NAME: Louise Koerting

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Henry J. Weyrich	3314 Edmondson Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary artery occlusion — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) aortic Insufficiency

DUE TO

(C) Rheumatic Cardio Vascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

420.1 1

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from October 19, 1954 to May 15, 1965, that (I) (~~we~~) last saw the deceased alive on May 14, 1965 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Harry L. Knipp, M.D. — Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐ — 23B. DATE SIGNED: 5-17-65

23C. PHYSICIAN'S NAME (Type): HARRY L. KNIPP, M.D.

23D. ADDRESS: 4116 Edmondson Ave. Baltimore Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	May 18/65	Loudon Park	Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robt E. Fahey, M.D.	Witzke F.D.	4101 Edmondson Ave

VS 150-REV. 1/1/65

D-5401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5212 — Registered No. 65 5212

1. NAME OF DECEASED (Type or Print): MRS. MARY E. DONNELLY
2. DATE AND HOUR OF DEATH: MAY 14, 1965 — M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 3912 Greenmount Ave
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) — A. STATE: Md. — B. COUNTY: 12-01 — C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE — D. STREET ADDRESS (If rural, give location): 3912 Greenmount Ave
5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: Sept. 6, 1890
9. AGE (In years last birthday): 75 — If Under 1 Yr. Months: Days: — If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: James Brazier
14. MOTHER'S MAIDEN NAME: Ellen Holleran
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — ADDRESS: Mary E. Scovern 3912 Greenmount Ave

MEDICAL CERTIFICATION

18. 420.1 I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenio, etc. It meons the diseose, injury or camplicatian which coused deoth.) — CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Coronary Thromboses — 30 minutes
OUE TO
(B) Arteio Sclerotic Vascular Disease — 6 years
OUE TO
(C) Cerebral Thromboses — 2 3days

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the abave couse (A) stating the UNDERLYING CONDITION lost.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: —
21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED — While At Work ☐ — Not While At Work ☐
21F. HOW DID INJURY OCCUR?: —

22. I certify that (I) (this hospital) attended the deceased from Dec 24 1962 to May 14 th 1965, that (I) (we) last saw the deceased alive on May 13th 1965 and that in(my) (~~our~~) opinion death occurred on the date and hour and from the couses stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: W M Conway — M.O. — Attending Phys. ☑ — Med. Director ☐ — Staff Phys. ☐
23B. DATE SIGNED: 5/14/65
23C. PHYSICIAN'S NAME (Type): W. M. Conway
23D. ADDRESS: M.O. 8358 Loch Raven Blvd Towson 4 Md

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 5/18/65
24C. NAME of CEMETERY or CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: MAY 17 1965
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR — ADDRESS: H.W. Mears & Son 805 N. Calvert St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-356 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5213 Registered No. 65 5213

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Wayne Stine

2. DATE AND HOUR OF DEATH: 5/12/65 8:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Frederick 60-00
D. STREET ADDRESS (If rural, give location): Rt #2

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	Single	2/2/45	20		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Lab Asst.	Hospital	Maryland	U. S.

13. FATHER'S NAME: Arthur Stine

14. MOTHER'S MAIDEN NAME: Mildred Free

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	219-44-3688	Arthur A. Stine	Thurmont, Md. RD 2

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO: Suspected Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO:

(C):

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Suspected test. tumor Widespread Metastases from — 3 mos.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 6 1965 to May 12 1965, that (I) (we) last saw the deceased alive on May 12 1965 and that in(my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Leif I. Solberg M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ — 23B. DATE SIGNED: 5/12/65

23C. PHYSICIAN'S NAME (Type): Leif I. Solberg M.D. — 23D. ADDRESS: University Hospitals

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-16-65	Resthaven Memorial Garden	Nr. Frederick Fred. Co Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Fabian M.D.	Raymond E. Craig	Thurmont, Md.

VS 150-REV. 1/1/65

43-27-69 1
FR
G-615

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 5214
M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5214

1. NAME OF DECEASED (Type or Print): Louis Griffin

2. DATE AND HOUR OF DEATH: April 30, 1965 | 9:00 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 12-04
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 208 E. 20th Street 21218

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Single	12-22-1892	72				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Connecticut	U. S. A.

13. FATHER'S NAME: John Griffin

14. MOTHER'S MAIDEN NAME: Mary Draper

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	090-14-3644A	RECORDS: BCH	4940 Eastern Avenue 21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — 331 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Pneumococcal Pneumonia	3 Days
DUE TO (B)	Arteriosclerotic Cerebral Vascular Disease with Right sided Cerebral Vascular Accident with left Hemiparesis	2 Years
DUE TO (C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from April 6, 19 65 to April 30, 19 65, that (I) (we) last saw the deceased alive on April 30, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
[signature]					April 30, 1965

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Dr. Howard Rathbun		4940 Eastern Avenue 21224

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/13/65	Glen Haven	AA Co. Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robt E. Faikyn	[signature]	

VS 150-REV. 1/1/65

G-416 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 64-32262 65 5215 Registered No. X 65 5215 C

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Glover, Scott F.

2. DATE AND HOUR OF DEATH: 12 May 65 | 11 15 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore, Co. Howard
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Simpsonville 63-00
D. STREET ADDRESS (If rural, give location): 203 Groveleigh Dr.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	Child	11/12/64		6			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Infant	Child	Baltimore, Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Glover, William F.	Mary Same

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No —	—	Hospital Charts	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
I	(A) Possible Asperation	2-3 minutes
	DUE TO Rubella Syndrome, C	6 mo's
	(B) DUE TO Congenital Heart And	
	(C) Opthamalogical Disease &	
	Severe Failure To Thrive	
II	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
23/9/65	PDA	YES	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No	—	—

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
—	While At Work ☐ Not While At Work ☐	—

22. I certify that (I) (this hospital) attended the deceased from 1 May 19 65 to 12 May 19 65, that (I) (we) last saw the deceased alive on 12 May 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
Rufus B. Jennings, M.					12 May 65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Rufus B. Jennings, Jr. M.D.	The Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	May 14, 1965	David Ridge Cemetery	Catonsville Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Talbert, M.D.	Hardy Funeral Home	4601 Harford Rd.

VS 150-REV. 1/1/65

K-002 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5216 Registered No. 65 5216

1. NAME OF DECEASED (Type or Print): Susie M. Kay.

2. DATE AND HOUR OF DEATH: May 13,1965 | 12:04 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Ardleigh Nursing Home 2095 Rockrose Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Cockeysville, Md 53-00
D. STREET ADDRESS (If rural, give location): Hillside Ave, Cockeysville, Md

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	white	married	June 19,1879	85				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Maryland	U.S.

13. FATHER'S NAME: Jacob M. Wilhelm.

14. MOTHER'S MAIDEN NAME: Ruth S. Ingham.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—	—	Charles W. Kay.	Hillside Ave.

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

I (A) DUE TO: Arteriosclerotic cardio-vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 15 yrs.

(B) DUE TO:

(C):

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from May 1 1965 to May 13, 1965, that (I) ~~(we)~~ last saw the deceased alive on May 12, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Lloyd E. Saylor M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: May 14. 1965

23C. PHYSICIAN'S NAME (Type): Lloyd E. Saylor M.D.

23D. ADDRESS: 3902 Greenmount Ave. Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/17/65	St. Mary's, Hampden	3900 Roland Ave, Balto Md

25A. DATE REC'D BY HEALTH DEPT.: MAY 17 1965

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Austin E. Donovan

ADDRESS: 3818 Roland Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V-5277 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5217 Registered No. 65 5217

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Katherine E. Jones

2. DATE AND HOUR OF DEATH: May 14, 1965 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location): 261 McCuelay St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 20-09
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 275 McCuelay St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Married	4/18/1880	85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John H. Lee	Mary J. Pyle

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—		Mr. William Jones	

MEDICAL CERTIFICATION

CAUSE OF DEATH

	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	INTERVAL BETWEEN ONSET AND DEATH
1B. 422.1 I	(A) Arteriosclerotic C.V.D.	years
	DUE TO (B)	
	DUE TO (C)	
	ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	
II	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 1965 to May 13 1965, that (I) (we) last saw the deceased alive on May 13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
J C Pound M.D.	Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐	5-14-65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
J. C. Pound M.D.	3325 Frederick av

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/17/65	Deer Creek Cem.	Bel-Air Md.

26A. DATE RECVD BY HEALTH DEPT	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Farley	G. Truman Schwab	3512 Frederick Ave. (29)

VS 150-REV. 1/1/65

G-61 3 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5218 Registered No. 65 5218

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): VIRGINIA GRIFFITH

2. DATE AND HOUR OF DEATH: MAY 15, 1965 | 550 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL BALTIMORE, MARYLAND - 21201

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY: Balto 25-04
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 25
D. STREET ADDRESS (If rural, give location): 4122 Hague Ave

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	M	11/25/18	46				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Md	USA

13. FATHER'S NAME: William Bennett

14. MOTHER'S MAIDEN NAME: Edna Wolfe

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Family	Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

I 1538

(A) ADENOCARCINOMA OF COLON, WITH SYSTEMIC METASTASES — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from APRIL 19 1965 to MAY 15 1965, that (I) (we) last saw the deceased alive on MAY 15 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Martin C. Shargel M.D. Attending Phys. ☐ Med. Director ☐ Stoll Phys. ☑ — 23B. DATE SIGNED: MAY 15, 1965

23C. PHYSICIAN'S NAME (Type): MARTIN C. SHARGEL M.D. — 23D. ADDRESS:

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/19/65	Cedar Hill	AA Co. Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 17 1965	Robert E. Farley, M.D.	McCully F.H. 237 Patapsco Ave 25

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

6-352 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5219 Registered No. 65 5219

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EVELYN REBECCA GITTINGS

2. DATE AND HOUR OF DEATH: MAY 9, 1965 | 7:45 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): U.S.P.H.S. Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before odmission)
A. STATE: Md. B. COUNTY: BALTO.
C. CITY OR TOWN (If outside city limits, write RURAL ond give township): BALTO 6300
D. STREET ADDRESS (If rurol, give locotion): JEFFERSON AVE.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In yeors lost birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	WID.	10/5/19	45				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
~~HOUSE WIFE~~	N.H. Balto. Co. Schools	Md.	U.S.

13. FATHER'S NAME: RUSSEL HARDCASTLE (teachers sec.)

14. MOTHER'S MAIDEN NAME: LAURA E. JOHNSON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): unkn.

16. SOCIAL SECURITY NO.: 216-16-0602

17. INFORMANT: HOSP. CHART ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 199.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not meon the mode of dying, e.g., heort foilure, asthenio, etc. It meons the disease, injury or complicotion which caused death.)

(A) DUE TO: Cerebral Hemorrhage Terminal

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if ony, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO: CARCINOMA (prim. undetermined) 1 mo. +

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
5/5/65	EVAC. CEREBRAL HEMATOMA duct. CA.	YES	YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)

21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exoct location)

21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospitol) ottended the deceosed from APRIL 25 1965 to MAY 9 1965, thot ~~(I)~~ (we) lost saw the deceased olive on MAY 9 1965 ond thot in ~~(my)~~ (our) opinion deoth occurred on the dote ond hour ond from the couses stoted obove. (I) ~~(We)~~ (did) (~~did not~~) view the body ofter deoth.

23A. SIGNATURE: Frank A. Bartkus M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: MAY 9, 1965

23C. PHYSICIAN'S NAME (Type): FRANK A. BARTKUS M.D.

23D. ADDRESS: U.S.P.H.S. HOSP. BALTO.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/13/65	Baltimore National Cemetery	Catonsville, Md.

25A. DATE REC'D BY HEALTH DEPT.: MAY 17 1965

25B. NAME OF REGISTRAR: Robert E. Faber, M.D.

25C. FUNERAL DIRECTOR ADDRESS: John Burns Sons Funeral Home

VS 150-REV. 3/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Z-5161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5220 Registered No. 65 5220

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ZEMBOWER, IRENE M.

2. DATE AND HOUR OF DEATH: 5/11/65 6:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Timonium 53-00
D. STREET ADDRESS (If rural, give location): 32 Belfast Rd.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	Cauc.	Widowed	12/3/97	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John J. Dunne	Winifred Burns

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	Hosp. Chart	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not meon the mode of dying, e.g., heart foilure, osthenio, etc. It means the diseose, injury or complicotion which coused deoth.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if ony, giving rise to the obove couse (A) stoting the UNDERLYING CONDITION lost.

		INTERVAL BETWEEN ONSET AND DEATH
I (A)	Congestive heart failure	7 days.
DUE TO (B)	Acute renal failure	8 days
DUE TO (C)	Abdominal aortic aneurysm	—
II	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
4/28/65 4/29/65, 5/3/65	Abd. aortic aneurysm Occlusion (L) Femoral artery	No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (Inside or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No		

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/25/ 1965 to 5/11/ 1965, that (I) (we) last saw the deceased alive on 5/11/ 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
Carl F. Berner					5/11/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
CARL F. BERNER		University Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/14/65	Dulaney Valley Memorial	Cockeysville, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 17 1965	E. Farley M.D.	John Burns Sons Funeral Home Towson

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-35|1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5221 — Registered No. 65 5221

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Alice N. Lautenberger

2. DATE AND HOUR OF DEATH: 5/8/65 | 10:30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY: 16-06
C. CITY OR TOWN (If outside city limits, write RURAL and give township): 2922 Kenson Nursing Home Arunah Ave
D. STREET ADDRESS (If rural, give location): Baltimore, Md

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	W	2/2/87	78				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Maryland	U.S.A.

13. FATHER'S NAME: Samuel Brown

14. MOTHER'S MAIDEN NAME: ~~Hat~~ ~~Keyes~~ Florence Brown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18.	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	
(A)	Respiratory Failure	1 Hr
DUE TO		
(B)	Pneumonia	3-4 Days
DUE TO		
(C)	Chronic Lung Disease	

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if ony, giving rise to the above couse (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 5/6/65 19 to 5/8/65 19, that (I) (~~we~~) last saw the deceased alive on 5/8/65 19 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
Charles A Aspley M.D.	Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒	5/8/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Charles H. Asplen M.D.	University Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/12/65	Druid Ridge Cem.	Pikesville, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Foskey M.D.	John Burns Sons	Towson

VS 150-REV. 1/1/65

A-500 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5222 Registered No. 65 5222

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Charles F. CALVIN HAHN

2. DATE AND HOUR OF DEATH 5-15-65 | 6 10 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 13-07
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 606 West 36th Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Widower	Sept. 25-1897	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Electrician	Bethlehem Steel	Pennsylvania	U.S.A.

13. FATHER'S NAME John Wesley Hahn

14. MOTHER'S MAIDEN NAME Alice Mace

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 216-07-0241

17. INFORMANT Charles C. Hahn Jr. ADDRESS 5514 Lagra Road

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 1538 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of colon DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-1 19 65 to 5-15 19 65, that (I) (we) last saw the deceased alive on 5-14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Perry L Shelton M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐ 23B. DATE SIGNED 5-15-65

23C. PHYSICIAN'S NAME (Type) Perry S. Shelton M.D. 23D. ADDRESS Mercy Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	May 18-65	Woodlawn	Baltimore Co. Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Faber, M.D.	Burgee Funeral Home Horace H. Burgee	2631 Falls Road

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Henry J. Gilliam
Edna S. Shelton
Wesley [illegible]
Bethune B. Humphrey

M-216 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5223 Registered No. 65 5223

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): MacPherson, Edward

2. DATE AND HOUR OF DEATH: May 11 1965 4.45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital Baltimore Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Worcester
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Snow Hill Maryland.
D. STREET ADDRESS (If rural, give location): 100 W. Washington St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	Married	5-26-92	62				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Milk Inspector	Dairy	PA.	USA.

13. FATHER'S NAME: William S. Macpherson

14. MOTHER'S MAIDEN NAME: Octavia L. Chick

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	213 01 5556	Catherine D. Macpherson	Snow Hill Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema
DUE TO
(B) Renal Bleage -
DUE TO
(C) Generalized Lymphosarcoma.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		YES	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 30 1965 to May 11 1965, that (I) (we) last saw the deceased alive on May 11 1965 and that In(my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
Paul L. Zikoski					5-11-65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Paul L. Zikoski		Univ. Hosp. Balto Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or ~~CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Burial	5/15/65	Bates Methodist	Snow Hill, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 17 1965	Robert E. Farley M.D.	Forman F. Flennis, Snow Hill, Md.

VS 150-REV. 1/1/65

BIRTH NO. 65 5224

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 5224

FUNERAL DIRECTOR: IMPORTANT This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

This was a patient of Dr. Ford Gordon (on vacation) & never saw the patient. Requested to sign certificate by Medical Examiner 6-21

1. NAME OF DECEASED (Type or Print): Minna A. Ullrich

2. DATE AND HOUR OF DEATH: May 13, 1965 | 9A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Gould Convalesarium 5900 elair Road #6

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 12-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore Md.
D. STREET ADDRESS (If rural, give location): 2917 Guilford Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Widowed	3-25-1886	79				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Housewife	Baltimore Md.	U.S.A.

13. FATHER'S NAME: Theodore A. Koletschke

14. MOTHER'S MAIDEN NAME: Agusta Ehmann

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	212-07-2093	Mrs Henry Schramm	7816 Ruxway Road 4

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(B) Anemia
DUE TO
(C) Sanility

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: CA of Stomac (Surgery 7 years)

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb. 1, 1965 to May 13 1965, that (I) (we) last saw the deceased alive on May 12, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: C. W. Peake M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐ — 23B. DATE SIGNED: 5-15-65

23C. PHYSICIAN'S NAME (Type): C. W. PEAKE M.D. — 23D. ADDRESS: 4508 Harford Road Balto 14 Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-17-1965	Immanuel Luth. Cemetery	Baltimore Md

25A. DATE RECD BY HEALTH DEPT.: MAY 17 1965 — 25B. NAME OF REGISTRAR: Robert E. Farley M.D. — 25C. FUNERAL DIRECTOR — ADDRESS: Lassahn Funeral Home 7401 Belair Road 36

VS 150-REV. 1/1/65

B-400 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5225

BIRTH NO.

M.E. CASE NO. 65 5225

1. NAME OF DECEASED (Type or Print) Ella Bailey

2. DATE AND HOUR OF DEATH 5-10-65--- II-P.M. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location)
Plaza Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 16-04
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, City
D. STREET ADDRESS (If rural, give location) 1909 Riggs Ave

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	Negro	Married	12-19-1881	83				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Baltimore	

13. FATHER'S NAME Williams

14. MOTHER'S MAIDEN NAME Emma

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Thomas Bailey	1909 Riggs Ave

MEDICAL CERTIFICATION

18. 443X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO Congenital degenerative Dis.

(B) DUE TO Hypostatic Congestion

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-31- 1964 to 5-10- 1965, that (I) (we) last saw the deceased alive on 5-10- 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED 5-12-65

23C. PHYSICIAN'S NAME (Type) GEO. H. PENDLETON M.D.

23D. ADDRESS 1723 Druid Hill Ave

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-14-65	Baltimore National	Baltimore City

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Farley, M.D.	Isaiah L. Brown & Son	108 W Montgomery St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 5226 M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5226

1. NAME OF DECEASED (Type or Print): CHARLES OR CARMEN JULIANO OR GUILIANO

2. DATE AND HOUR OF DEATH: 5/16/65 2.15 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 906 FAWN ST. BALTO. Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: BALTO. 3-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO.
D. STREET ADDRESS (If rural, give location): 906 FAWN ST.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	SINGLE NEVER MARRIED	MAY 4th 1903	62				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
BARBER	MENS BARBER	BALTO. Md.	u.s.a.

13. FATHER'S NAME: VINCENZO JULIANO

14. MOTHER'S MAIDEN NAME: ADELAIDE MARINO

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	219-07-3658	MARIE JULIANO	906 FAWN ST.

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
1B. 782.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) DUE TO Myocardial failure	2 wks
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (~~this hospital~~) attended the deceased from 5/15 19 65 to 5/16 19 65, that (I) (~~we~~) last saw the deceased alive on 5/13 19 65 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☒	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
Joseph R. Liberto					5/17/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
JOSEPH R. LIBERTO		3508 BANK ST.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/18/65	HOLY REDEEMER	4400 BELAIR RD. BALTO. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Farley M.D.	Frank Della Vecchia	322 S. High St.

VS 150-REV. 1/1/65

1

S-400

BIRTH NO. 65 5227

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5227

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JULIUS SELL

2. DATE AND HOUR PRONOUNCED DEAD: May 1, 1965 11:45 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 402 W. Pratt St.

4-01

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
male	white			57				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fatty metamorphosis of liver — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Hypertensive heart disease

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 5-3-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME OF CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
	MAY 13 1965	ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL	

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR OR AUTHORIZED AGENT	ADDRESS
MAY 17 1965	Robert E. Fahnestock	MORTUARY SERVICE - BCHD	

VS 151-REV. 1/1/65

1

M-000

10912

Some viscera

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 65 5228 Registered No. 65 5228

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): RICHARD MAYO

2. DATE AND HOUR PRONOUNCED DEAD: 4-26-65 1:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 1044 SOMERSET STREET

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-01
D. STREET ADDRESS (If rural, give location): 1044 Somerset Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M ale	Colored			66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

491 X

(A) ~~XXXX~~ Bronchopneumonia

Complicating Arteriosclerotic cardio-vascular disease

(B) DUE TO

(C)

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Peter W. Rieckert M.D.

EXAMINER'S NAME (Type): PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED: 4-26-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town or county) (State)
	MAY 13 1965	ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL	

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robt E. Falkenhagen	MORTUARY SERVICE - BCHD	

VS 151-REV. 1/1/65

1

J-520

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 65 5229 Registered No. 65 5229

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CLAUDE E. JONES	2. DATE AND HOUR PRONOUNCED DEAD: 4-26-65 | 1:30 P.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 328 W. CAMDEN STREET	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-12 D. STREET ADDRESS (If rural, give location): 328 W. Camden Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White			75 ?		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease 422.1

DUE TO

ANTECENDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE H W Kiel M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type) PETER W. RIECKERT, M.D.

DATE SIGNED 4-26-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
	MAY 13 1965	ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL	

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Farley M.D.	MORTUARY SERVICE - BCHD	✓

VS 151-REV. 1/1/65

BIRTH NO. 65-11517 65 5230

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 5230

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Thomas, baby boy

2. DATE AND HOUR OF DEATH: May 15, 1965 | 9:05 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH HOME & HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 8165 Del Haven Rd.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Infant	5/14/65 11:55 PM				8	10

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore	

13. FATHER'S NAME: Anthony Thomas

14. MOTHER'S MAIDEN NAME: Gloria Loukonen

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Anthony Thomas.	Same as above.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 776X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Immaturity, 26 weeks — INTERVAL BETWEEN ONSET AND DEATH: 8 Hrs. & 10 Min.

1 lb. 1 oz.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from May 14 11:58 PM 1965 to May 15 9:05 AM 1965, that (I) (we) last saw the deceased alive on May 15 9:05 AM 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	23B. DATE SIGNED
Cesar J. Bariso,	Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑	5-15-65

23C. PHYSICIAN'S NAME (Type): CESAR R. BARISO, M.D.

23D. ADDRESS: Church Home & Hospital, Balto. Md.

ANATOMY BOARD OF MARYLAND

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, Town or County) (State)
	MAY 17 1965	JOHNS HOPKINS MEDICAL SCHOOL	

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 17 1965	Robert E. Fabian, M.D.	MORTUARY SERVICE - BCHD	

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-4521

BIRTH NO. 65 5231

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 5231

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): AMELIA BIELAMOWICZ

2. DATE AND HOUR OF DEATH: 5-16-65 | 10.00 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): CHURCH HOME & HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY: 2-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO.
D. STREET ADDRESS (If rural, give location): 2016 E. Lombard ST.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	MARRIED	4-25-1907	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Md.	USA

13. FATHER'S NAME: ANTHONY BRZOSTEK

14. MOTHER'S MAIDEN NAME: J. JAKUBOWSKI

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.

17. INFORMANT: HENRY BIELAMOWICZ ADDRESS: 2016 E. LOMBARD ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) BRAIN TUMOR — INTERVAL BETWEEN ONSET AND DEATH: days

DUE TO

(B) DIABETES MELLITUS — YEARS

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C) TERMINAL BRONCHOPNEUMONIA

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-24 19 65 to 5-16 19 65, that (I) (we) last saw the deceased alive on 5-16 19 65 and that In(my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Ephraim B. Barzaga M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 5-16-65

23C. PHYSICIAN'S NAME (Type): EPHRAIM B. BARZAGA M.D.

23D. ADDRESS: CHURCH HOME & HOSP. BALTO-31, Md

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 5-20-1965

24C. NAME of CEMETERY or CREMATORY: HOLY ROSARY CEM

24D. LOCATION (City, town, or county) (State): DUNDALK MD

25A. DATE REC'D BY HEALTH DEPT.: MAY 18 1965

25B. NAME OF REGISTRAR: Robert E. Faber, M.D.

25C. FUNERAL DIRECTOR ADDRESS: JOHN M. WEBER & SONS INC. 401 S. CHESTER ST

VS 150-REV. 1/1/65

S-612 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65-5232 Registered No. 65 5232

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) SHARPS GEORGE HENRY

2. DATE AND HOUR OF DEATH 14-May 65 | 1250 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE md B. COUNTY ?

C. CITY OR TOWN (If outside city limits, write RURAL and give township) Crownsville md

D. STREET ADDRESS (If rurol, give locotion) Crownsville State Hosp

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In yeors lost birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	C	M	1-8-1897	68				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Branchsha Sharps

14. MOTHER'S MAIDEN NAME Rebecca - Gray

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No (If yes, give wor or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT Alverta Harris ADDRESS 5 Rideout Ave Annapolis Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not meon the mode of dying, e.g., heort lailure, osthenio, etc. It meons the diseose, injury or complicotion which coused deoth.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if ony, giving rise to the obove couse (A) stating the UNDERLYING CONDITION last.

I 420.1

(A) Myocardial Infarction — DUE TO

(B) Coronary Arteriosclerosis — DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. generalized Arteriosclerosis

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exoct locotion)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/11/65 19 to 5/14/65 19, that (I) (we) last saw the deceased alive on 5/14/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type) Jesse A. Marcel M.D.

23D. ADDRESS c/o University Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-18-65	Friendship	Friendship Md.

25A. DATE REC'D BY HEALTH DEPT. MAY 18 1965

25B. NAME OF REGISTRAR Robert E. Farley M.D.

25C. FUNERAL DIRECTOR William Reese ADDRESS Anna. Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

T-520

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 65 5233 Registered No. 65 5233

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ROBERT E. THOMAS

2. DATE AND HOUR PRONOUNCED DEAD: 5/14/65 12:45 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Monkton
D. STREET ADDRESS (If rural, give location): Big Falls Rd.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
male	white	Married	Sept. 15, 1924	40		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Longshoreman -	Shipbuilding -	Washington Co., Va.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Hobart Ballard Thomas	Hattie May Heath

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes WW II	214-18-6470	Mrs. Irene Thomas, Monkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

E822.4

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia complicating fracture of pelvis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
24		yes	yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	street	Bernoudy Rd. Balto. Co. 5-3-00

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
5 4 65 11:31 a.m.	WHILE AT WORK [x] NOT WHILE AT WORK [ ]	jeep fell on subject

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [x] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [x] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE Werner U. Spitz M.D.
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
ASSOCIATE MEDICAL EXAMINER [x]
DATE SIGNED 5/14/65

23A. BURIAL, CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/17/65	Hereford Baptist Cem.	Hereford, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 18 1965	Robert E. Foster, M.D.	J. Jacob Hartenstein	New Freedom, Pa.

VS 151-REV. 1/1/65

N 8-08-2

Jeep overturned - Info from M.E. - 9a
by Phone

1

65 5234

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65 5234

BIRTH NO.

M.E. CASE NO.

Registered No.

H-452

1. NAME OF DECEASED (Type or Print): JAMES F. HOLMES

2. DATE AND HOUR PRONOUNCED DEAD: 5/14/65 8:00 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Towson
D. STREET ADDRESS (If rural, give location): 609 Deaugh Ave. Debaugh Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 1 Yr. Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.
male	white	married	July 22, 1913	52				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
General foreman	Armco Steel Corp.	Delaware	USA

13. FATHER'S NAME: Thomas Holmes

14. MOTHER'S MAIDEN NAME: Sarah Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	none	212-05-7574	Family records	

MEDICAL CERTIFICATION

18. 422.1 i

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		yes	yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Werner U. Spitz M.D.

EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED 5/14/65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/17/65	Dulaney Valley Mem.	Cockeysville, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 18 1965	Robert E. Farley M.D.	John Burns Sons Towson 4, Md.

VS 151-REV. 1/1/65

M-6251 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5235 Registered No. 65 5235

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): BARTON A. MERCHANT.

2. DATE AND HOUR OF DEATH: May 14, 1965 | 10:50 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Cockeysville
D. STREET ADDRESS (If rural, give location): 21 Oakknoll Rd.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W		April 5, 1953	12				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
student	School	Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Robert Merchant	Bessie Wirts

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 2748 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Bilateral multilobar pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO: Possible adrenal insufficiency secondary to hemorrhage

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes) or No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		(Yes)	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 13 19 65 to May 14 19 65, that (I) (we) last saw the deceased alive on May 14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
Nieva G. Valle					May 14, 1965

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
NIEVA G. VALLE		Maryland General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/17/65	Dulaney Valley Mem.	Cockeysville Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 18 1965	Robert E. Farley, M.D.	John Dennis Son's	Towson

VS 150-REV. 1/1/65

N-132 1

Zabetakis, John 2-03 9463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5236 Registered No. 65 5236

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Zabetakis, John

2. DATE AND HOUR OF DEATH: 5/15/65 5:30 a M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1708 Alice Ann St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	married	6/23/90	74				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Baker -	H+S Bakery	GREECE	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
EMANUEL ZABETAKIS	ANNA ROMANIAS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Family	Same

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
1B. 156.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(B) DUE TO	
	(C) Carcinoma of ~~Uterus~~ LIVER	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/29 19 65 to 5/15 19 65, that (I) (we) last saw the deceased alive on 5/15/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Stoll Phys. ☒	23B. DATE SIGNED
John F Bigger, Jr MD					5/15/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
JOHN F. BIGGER		JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-18-65	Crucanth. Cem.	Balto Co MD

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 18 1965	Robert E. Farley, M.D.	McCully Funeral Home	237 Pittsboro Ave

VS 150-REV. 1/1/65

5-15-65

RELEASED AS NON MED BY DR CENDAN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-650 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5237

Registered No. 65 5237

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Jessie P. Grim (Grimm)

2. DATE AND HOUR OF DEATH: 5/14/65 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 3 800 10th St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 25-04
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 3800 10th St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	WHITE	Widow	12/25/93	71				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Alabama	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unk	Unk

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Family	Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not meon the mode of dying, e.g., heart foilure, osthenio, etc. It meons the diseose, injury or complicotion which coused deoth.)

(A) DUE TO: generalized carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if ony, giving rise to the above couse (A) stoling the UNDERLYING CONDITION lost.

(B) DUE TO: primary Ca of colon — 7 yrs

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
O		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Boltimore City, give exoct locotion)

21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Oct 19 38 to May 14 19 65, that (I) (we) last saw the deceased alive on May 14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	23B. DATE SIGNED
Philip W. Kuster	Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐	5/15/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
KEISTER		302 Patapsco Ave

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/18/65	National Cem.	Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 18 1965	Robt E. Fabian, M.D.	McCully Funeral Hm. 237 Patapsco Ave.

VS 150-REV. 1/1/65

1

W-536

65 5238

BALTIMORE CITY HEALTH DEPARTMENT

65 5238

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): PAUL H. WINTER

2. DATE AND HOUR PRONOUNCED DEAD: 5-16-65 | 5:55 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): ST. AGNES HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: 25-52

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1626 Parkman Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	MARRIED	FEB. 27, 1926	39		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
MILK MAN	Dairy Products	MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Louis G. WINTER	HELEN SMITH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES WORLD WAR II	320-18-8294	MRS. BETTY J. WINTER	1626 PARKMAN AVE

MEDICAL CERTIFICATION

18. 3277

CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute cor pulmonale

DUE TO

Chronic pulmonary emphysema

ANTECENDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Russell S. Fisher M.D.

EXAMINER'S NAME (Type): RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 5-17-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
BURIAL	5-20-65	MEADOWRIDGE MEMORIAL	HOWARD CTY MD

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 18 1965	Robert E. Farley M.D.	GEO. L. SCHWAB FUNERAL HOME Francis W. Miller 2101 Hurdwick Ave.

VS 151-REV. 1/1/65

C-650 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5239 Registered No. 65 5239

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CURRAN, WILLIAM GIBBONS

2. DATE AND HOUR OF DEATH: 5-16-65 | 6:05 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL BALTIMORE, MARYLAND 21229

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): PIKESVILLE
D. STREET ADDRESS (If rural, give location): 27 WALKER AVENUE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	WHITE	MARRIED	7-19-13	51		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
MEAT CUTTER	FOOD MARKET	MARYLAND	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
WILLIAM P CURRAN (DEC'D)	MARIE MORAN (DEC'D)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	212078128	ST. AGNES HOSPITAL RECORDS	BALTO. 29, MD

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) DUE TO: Pericarditis + mediastinitis	3 days
ANTECEDENT CAUSES: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(B) DUE TO: Carcinoma of Esophagus	weeks
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
5-13	esophago-gastrostomy	YES	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-10 1965 to 5-16 1965, that (we) last saw the deceased alive on 5-16-65 1965 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
[signature] M.D.	Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒	5-16-65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
PEDRO P. PURCELL, MD M.D.	

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/20/65	Cathedral Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 18 1965	Robert E. Fisher, M.D.	Lowell Lemmon	4611 Park Heights Av

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Date of operation 4/27/65 - Inform. received by phone from St. Agnes Hosp. 9a.

1

6-600

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 5240

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5240

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) John Costin Gray	2. DATE AND HOUR PRONOUNCED DEAD May 15 1965 11:59 P M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 South Baltimore General Hospital	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 21-01 D. STREET ADDRESS (If rural, give location) 743 W. Cross Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Widowed	8-16-81	83				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tool Clerk	Shipping	Pa	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	162166127	Shirley Gray	Alone

MEDICAL CERTIFICATION

18. 4437

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Hypertensive and arteriosclerotic

DUE TO cardiovascular disease

INTERVAL BETWEEN ONSET AND DEATH

ANTECENDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		no	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE John E. Adams M.D.

EXAMINER'S NAME (Type) John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED May 16, 1965

23A. BURIAL, CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5-19-65	Glen Haven	Glen Burnie, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 18 1965	Robert E. Farley M.D.	John J. Cowan & Son Inc	Balto. 23, Md.

VS 151-REV. 1/1/65

5-620 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5241 Registered No. 65 5241

1. NAME OF DECEASED (Type or Print): Sczurowski, John

2. DATE AND HOUR OF DEATH: May 14, 1965 | 8:30 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 9-06
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21218
D. STREET ADDRESS (If rural, give location): 1704 E. 30th St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	9-9-1906	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machine Opr.	Union Bag Co.	Baltimore, Maryland	

13. FATHER'S NAME: Alexander Sczurowski

14. MOTHER'S MAIDEN NAME: Frances Olszewski

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Stella Lisiecki Sczurowski	wife, above

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
1B. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Bronchogenic carcinoma	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	DUE TO (B)	
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 10, 1965 to May 14, 1965, that (I) (we) last saw the deceased alive on May 14, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☑	23B. DATE SIGNED
					May 14, 1965

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Anastacio E. Subong, Jr.		1400 N. Caroline St., Baltimore, Md. 21213

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/17/65	St. Stanislaus Cem.	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 18 1965	Robert E. Farkey, M.D.	Schimunek Funeral Home, Inc. 3331 Brehms Lane

VS 150-REV. 1/1/65

T-600 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5242 Registered No. 65 5242

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BERNARD John TURWY

2. DATE AND HOUR OF DEATH: 5-15-65 | 4 15/A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION: Mercy
(If not in hospital or institution, give street address or location)
31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: 2-6-10
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 442 N. Bouldin St., Zone 24

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
male	white	married	1/15/1894	71				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Engineer	Pa. R. R.	Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
unknown	unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	Navy-W.W.1		Florence Bohager Turwy, wife, above	

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Chronic Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 3-4 YRS.
DUE TO
(B) Chronic atrial Fibrillation — ?
DUE TO
(C) ASCVND — ?

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		N/o	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No		

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from 5-4- 1965 to 5-15- 1965, that (I) (we) last saw the deceased alive on 5-15- 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
Robert L. Doyle		☐	☐	☒	5-15-65

23C. PHYSICIAN'S NAME (Type) M.D. 23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/18/65	Holy Redeemer Cem.	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 18 1965	Robert E. Farley M.D.	Schimunek Funeral Home, Inc. 3331 Brehms Lane

VS 150-REV. 1/1/65

F260 1

EXAMINER PER DR ADAMS

FOR Approval of Medical

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5243 — Registered No. 65 5243

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Fischer M. Edith (Fischer)

2. DATE AND HOUR OF DEATH: 5/14/65 — 7:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location): 33 The Johns Hopkins Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY: 7112 Greenwood Ave Balto.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): 7112 Greenwood Ave Balto
D. STREET ADDRESS (If rutol, give location): Balto 21206 53 MD

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Married	10-07-1914	50				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Planter in Hot House (Ecks Florist House Wife)		Baltimore, Md.	U S

13. FATHER'S NAME: Thomas Johns

14. MOTHER'S MAIDEN NAME: Louise Zimmeran

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 212-22-8315

17. INFORMANT — ADDRESS: Andrew J. Fischer, husband, above

MEDICAL CERTIFICATION

CERTIFICATION APPROVED BY: [signature] CHIEF OR ASST. MEDICAL EXAMINER

18. 722.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not meon the mode of dying, e.g. heart failure, osthenio, etc. It meons the diseose, injuiy or complicotion which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: probable brain stem damage — 2 hrs

(B) DUE TO: 2° odontoid removal for

(C) subluxation odontoid into foramen magnum due to Rheumatoid arthritis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if ony, giving rise to the above couse (A) stoting the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
5/13/65	odontoid herniation	YES	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
NO		

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: White At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify thot (I) (this hospitol) ottended the deceosed from 5/13 19 65 to 5/14 19 65, thot (I) (we) lost sow the deceased olive on 5/14 19 65 ond thot in (my) (our) opinion deoth occurred on the dote ond hour ond from the couses stoted obove. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☑	23B. DATE SIGNED
E D Lyne					5/14/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
E. DENNIS LYNE		The Johns Hopkins Hosp

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/18/65	Gardens of Faith Cem.	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR — ADDRESS
MAY 18 1965	Robert E. Farley M.D.	Schimunek Funeral Home, Inc. 3331 Brehms Lane

VS 150-REV. 1/1/65

1

K-435

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 65 52 Registered No. 65 5244

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARY R. KALTENHAUSER

2. DATE AND HOUR PRONOUNCED DEAD: 5-17-65 8:20 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): JOHNS HOPKINS HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-04
D. STREET ADDRESS (If rural, give location): 2211 E. Preston Street

33/69

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	widowed	12/28/89	75				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machine Opr.	Calvert Distillery	Baltimore, Md.	

13. FATHER'S NAME: Joseph Rayman

14. MOTHER'S MAIDEN NAME: Barbara Brooks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	217-09-0360	Marie Rasin, dght.	739 N. Chester St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

422.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Russell S Fisher M.D.

EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 5-17-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/20/65	Holy Redeemer Cem.	Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 18 1965	Robert E. Farley M.D.	Schimunek Funeral Home, Inc. 2801 E. Madison St.

VS 151-REV. 1/1/65

S-364 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5245 — Registered No. 65 5245

1. NAME OF DECEASED (Type or Print): BENJAMIN F. SUTHERLAND
2. DATE AND HOUR OF DEATH: 5-15-65 | 9 P.M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) — A. STATE: Maryland — B. COUNTY: 11-02 — C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore — D. STREET ADDRESS (If rural, give location): 7 East Center Street
5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: April 7 1873
9. AGE (In years last birthday): 92 — If Under 1 Yr. Months / Days — If Under 24 Hrs. Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Decorator
10B. KIND OF BUSINESS OR INDUSTRY: Paper Hanging
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Sutherland
14. MOTHER'S MAIDEN NAME: Lydia Emma Taylor
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Helen B. D. Buckley — ADDRESS: 5723 Falls Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
I (A) DUE TO	Congestive Heart Failure	HRS
(B) DUE TO	Arteriosclerotic Heart Disease	YRS
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Malnutrition	

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED — While At Work ☐ — Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-15 1965 to 5-15 1965, that (I) (we) last saw the deceased alive on 5-15 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: William R Law M.D. — Attending Phys. ☐ — Med. Director ☐ — Staff Phys. ☒
23B. DATE SIGNED: 5-16-65
23C. PHYSICIAN'S NAME (Type): WILLIAM R LAW M.D.
23D. ADDRESS: MERCY HOSP BALTO. MD

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: May 19-1965
24C. NAME of CEMETERY or CREMATORY: Loroms Presbyterian
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT.: MAY 18 1965
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Burgee Funeral Home — ADDRESS: 3631 Fall Road
Horace F. Burgee

VS 150-REV. 1/1/65

1

L-518

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 65 5246 Registered No. 65 5246

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Gerhard JULIUS LAMPE

2. DATE AND HOUR PRONOUNCED DEAD: 5/14/65 2:30 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

48 Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 3-8-04
D. STREET ADDRESS (If rural, give location): 618 Winans Way 29

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	If 100 or over, last birthday	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
male	white	Married	6/26/1871	93		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
President S.M. Dell Co.	Paint Brush Mfgr.	Frederick, Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Henry Lampe	Elizabeth Hoss

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No None		5402 Stuckley Ave. Mr. J. Harold Lampe Norfolk, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
I 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Arteriosclerotic cardiovascular disease	
DUE TO (B)	
ANTECENDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		no	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Werner U. Spitz M.D.

EXAMINER'S NAME (Type) W.U. Spitz, M.D.

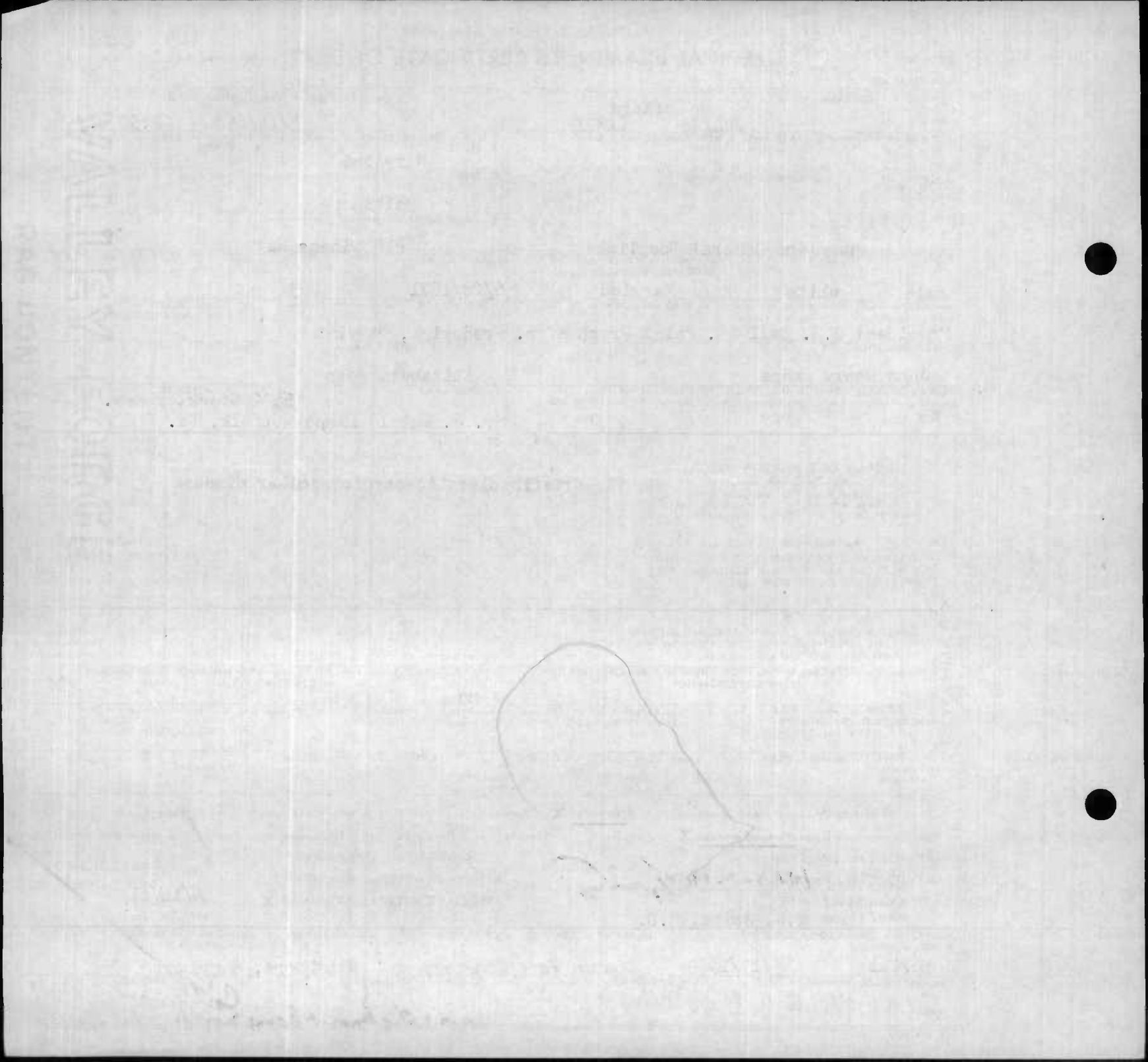
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED 5/14/65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/17/1965	Loudon Park Cemetery	Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 18 1965	Robert E. Farley, M.D.	Wm. J. Tickner & Sons North Pa. Aves. Balto., Md. 21217

VS 151-REV. 1/1/65



F-260 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5247 Registered No. 65 5247

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Dolores E. Fisher

2. DATE AND HOUR OF DEATH: May 14 1965 | 5 15 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 21117 Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Owings Mills 53-00
D. STREET ADDRESS (If rural, give location): Box 310 - Garrison Forrest Rd

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	Married	7-26-32	32				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Maryland	USA

13. FATHER'S NAME: Richard Moats

14. MOTHER'S MAIDEN NAME: Agnes Higgins

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 213-30-8710

17. INFORMANT: Charles Fisher ADDRESS: Garrison Forest Rd. Owings Mills, Md.

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Carcinoma of uterine cervix with generalized — INTERVAL BETWEEN ONSET AND DEATH: 4 months
DUE TO
(B) Metastasis
DUE TO
(C) Cachexia.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-11 1965 to 5-14 1965, that (I) (we) last saw the deceased alive on 5-14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Jain M Lee M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 5-14-65

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS: 827 Linden Ave., Balto. Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/17/65	Evergreen Mem. Gardens	Finksburg, Maryland

25A. DATE REC'D BY HEALTH DEPT.: MAY 18 1965 | 25B. NAME OF REGISTRAR: Robert E. Foster, M.D. | 25C. FUNERAL DIRECTOR: H. J. Eckhardt ADDRESS: Owings Mills, Md.

VS 150-REV. 1/1/65

K-413 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5248 Registered No. 65 5248

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Anthony J. Kalvitis

2. DATE AND HOUR OF DEATH: May 16, 1965 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 5519 Bucknell Rd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: -----
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-01
D. STREET ADDRESS (If rural, give location): 5519 Bucknell Rd.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	May 28, 1915	49 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Army Training Devices	Aberdeen P.G.	Dickson City, Pa.	U.S.A.

13. FATHER'S NAME: Joseph Kalvitis

14. MOTHER'S MAIDEN NAME: Anna

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	----------	323-14-8455	Bella Kalvitis	5519 Bucknell Rd.

MEDICAL CERTIFICATION

18. 420.1 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPRDX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 5/12 1965 to 5/16 1965, that (I) (~~we~~) last saw the deceased alive on 5/14 1965 and that in(my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☑	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
Albert C. Herrmann					5/17/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Albert C. Herrmann		4420 Minnesota Ave. 21206

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial ~~EXXX~~	May 19, 65	Gardens of Faith Cem.	Trumps Mill Rd. 21206

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 18 1965	Robert E. Faber M.D	The Dippel Brothers	7110 Belair Road

VS 150-REV. 1/1/65

L-520 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5249 Registered No. 65 5249

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Elizabeth Gertrude Lynch

2. DATE AND HOUR OF DEATH: 5-17-65 | 1:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 2710
D. STREET ADDRESS (If rural, give location): 503 E 43rd Street

5. SEX: F | 6. RACE: W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M

8. DATE OF BIRTH: 3-23-19 | 9. AGE (In years last birthday): 46 ~~46~~ ~~47~~ | If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry Lee Fregze
14. MOTHER'S MAIDEN NAME: Blanche Cauliflower

15. Was Deceased ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: yes
17. INFORMANT: Mr. T. Stanley Lynch
ADDRESS: 503 E. 43rd St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
I (A)	Ventricular fibrillation	1 hour
DUE TO (B)	Myocardial Infarction	19 days.
DUE TO (C)		

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: White At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-28 19 65 to 5-17 19 65, that (I) (we) last saw the deceased alive on 5-17 19 65 and that in (my) (our) opinion death occurred an the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Rodney L. Brimhall M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 5-17-65
23C. PHYSICIAN'S NAME (Type): RODNEY L. BRIMHALL M.D.
23D. ADDRESS: Union Memorial Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 5/20/65
24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery
24D. LOCATION (City, town, or County) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: MAY 18 1965
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: John A. Moran, Inc.
ADDRESS: 3000 E. Balto. St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-325 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5250 Registered No. 65 5250

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Catherine Mary Hudson

2. DATE AND HOUR OF DEATH: May 16, 1965 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 231 Kenwood Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 6-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 231 N. Kenwood Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	Widowed	Nov. 17, 1887	77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Roscommon, Ireland	USA

13. FATHER'S NAME: Thomas Croghan

14. MOTHER'S MAIDEN NAME: Mary McDermott

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	Mr. William Hudson	231 N. Kenwood Ave

MEDICAL CERTIFICATION

18. 420.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: Arteriosclerotic Heart Disease Ch Congestive failure

(B) DUE TO: Cerebral arteriosclerosis

(C) Ch Brain Syndrome

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bronchopneumonia

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Feb 1 1965 to May 16 1965, that (I) (we) last saw the deceased alive on May 14 1965 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~and~~) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
Donald W. Mintzer M.D.	Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐	5/17/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
DONALD W. MINTZER M.D.	3009 EVERGREEN AVE BALTO 17

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/19/65	New Cathedral Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 18 1965	Robert E. Faherty	John A. Moran, Inc.	3000 E. Balto. St.

VS 150-REV. 1/1/65

SAB-43-55-49

BIRTH NO. 65-10721 65 5251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5251

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Baby Boy Washington-~~Betty~~ Jean

2. DATE AND HOUR OF DEATH: 5-10-1965 | 1.35 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 8-07

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1239 N. Broadway 21213

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Negro	Never Married	5-9-1965				16	38

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	U.S.A.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME: Betty Jean

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Records: BCH-4940 Eastern Avenue	21224

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 773.51 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory Distress Syndrome — INTERVAL BETWEEN ONSET AND DEATH: 7½ hours

DUE TO

Prematurity

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from 5-9- 19 65 to 5-10- 19 65, that (I) (we) last saw the deceased alive on 5-10- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
S. Wayne Klein		☐	☐	☒	5-10-1965

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Dr. S. Wayne Klein		4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremated	5-13-1965	Baltimore City Hospitals	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 18 1965	Robert E. Fahey, M.D.	HOSPITAL DISPOSAL	

VS 150-REV. 1/1/65

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5252 — Registered No. 65 5252

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EDNA DAVIS

2. DATE AND HOUR OF DEATH: 5-15-65 — 7:10 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND — B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township): LUTHERVILLE
D. STREET ADDRESS (If rural, give location): 25 BELMORE RD.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
FEMALE	WHITE	MARRIED	9-28-16	~~49~~ 48				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Book Binder	Stationary Business	Balto. Md.	

13. FATHER'S NAME: HOWARD HENTZ

14. MOTHER'S MAIDEN NAME: LILLIAN MILLS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 211-09-9887

17. INFORMANT: MR. HOWARD DAVIS — ADDRESS: 25 BELMORE AVE. LUTHERVILLE MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not meon the mode of dying, e.g., heart foilure, osthenio, etc. It meons the diseose, injury or complicotion which coused deoth.)

(A) Recurrent Mitral Stenosis — INTERVAL BETWEEN ONSET AND DEATH: 30 yr.

DUE TO

(B) Rheumatic Heart Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if ony, giving rise to the obove couse (A) stoting the UNDERLYING CONDITION lost.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
5-11-65	Mitral Stenosis	Yes	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No	No	—

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
—	While At Work ☐ — Not While At Work ☐	—

22. I certify that (I) (this hospital) attended the deceased from 5-5-65 19 65 to 5-15 19 65, that (I) (we) last saw the deceased alive on 5-15 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
John D. Harrah, M.D.	M.D.	☐	☐	☑	5-15-65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
JOHN D. HARRAH	M.D.	JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/19/65	Mt. Olivet Cem.	Frederick Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 18 1965	Robert E. Talley, M.D.	G. TRUMAN SCHUAB	3512 Frederick Ave. (29)

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospitol (except where the physicion who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650 1

BIRTH NO. 65 5253

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

65 5253 Registered No.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): LLOYD H. BROWN

2. DATE AND HOUR OF DEATH: 5/13/65 | 833 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD B. COUNTY: PRINCE GEORGE
C. CITY OR TOWN (If outside city limits, write RURAL and give township): HYATTSVILLE
D. STREET ADDRESS (If rural, give location): 7319 ROXBERRY COURT

5. SEX: M | 6. RACE: W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed | 8. DATE OF BIRTH: [illegible] 7/92 | 9. AGE (In years last birthday): 72 | If Under 1 Yr. Months / Days | If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Clerk
10B. KIND OF BUSINESS OR INDUSTRY: Hardware Store
11. BIRTHPLACE (State or foreign country): =Iowa
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: David Brown
14. MOTHER'S MAIDEN NAME: Nancy Jane ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 482-10-0116
17. INFORMANT: ROBERT BROWN ADDRESS: 7319 ROXBERRY COURT, HYATTSVILLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PROBABLE CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

DUE TO

(B) ARTERIOSCLEROTIC HEART DIS — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: no

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/12 19 65 to 5/13 19 65, that (I) (we) last saw the deceased alive on 5/13 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Robert W. Hamilton M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 5/13/65
23C. PHYSICIAN'S NAME (Type): Robert W. Hamilton M.D.
23D. ADDRESS: UNIVERSITY HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 5/18/65
24C. NAME of CEMETERY or CREMATORY: Glendale
24D. LOCATION (City, town, or county) (State): Des Moines, Iowa

25A. DATE REC'D BY HEALTH DEPT.: MAY 18 1965
25B. NAME OF REGISTRAR: Robert E. Farber M.D.
25C. FUNERAL DIRECTOR ADDRESS: Francis Gasch's Sons Hyattsville, Md.

VS 150-REV. 1/1/65

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5254 Registered No. 65 5254

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JESSIE B. BRINKLEY

2. DATE AND HOUR OF DEATH: 5-14-65 6.15 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD. B. COUNTY: BALTI
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2015 E. HOFFMAN STREET

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
FEMALE	NEGRO	MARRIED	7-18-10	54				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	own home	Vaughn, N.C.	U.S.A.

13. FATHER'S NAME: TOM WILLIAMS

14. MOTHER'S MAIDEN NAME: MARTHA VINCENT

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	None	William Brinkley	2015 E. Hoffman St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) METASTATIC CARCINOMA — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

DUE TO (B) CARCINOMA OF COLON — ?

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: NONE

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
6/64 - 12/64	CA COLON	Yes	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 8 1965 to May 14 1965, that (I) (we) last saw the deceased alive on May 14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J. Gregory Kane M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ — 23B. DATE SIGNED: 5/14/65

23C. PHYSICIAN'S NAME (Type): J. GREGORY KANE M.D. — 23D. ADDRESS: JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-17-65	Arbutus Memorial Pk.	Arbutus, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR — ADDRESS
MAY 18 1965	R. L. & E. Farber M.D.	Randolph J. Collick 1412 E. Preston St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B1552 1 3011 96 RS BRINKLEY, JESSIE

W-314 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5255 Registered No. 65 5255

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Whitfield, Walter

2. DATE AND HOUR OF DEATH 5-14-65 | 3:25 A M.

3. PLACE OF DEATH: BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location) 36 Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 18-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 23
D. STREET ADDRESS (If rural, give location) 918 N. Saratoga St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	N.	~~MARRIED~~ WIDOWED	10/12/1902	62				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Plumbing Supply	NC.	U. S. A.

13. FATHER'S NAME ~~Rayla~~ REUBEN Whitfield

14. MOTHER'S MAIDEN NAME Rossa Good

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		243-07-6680	Albert Dinkins (Friend) Margie Whitfield (wife)	918 N. Saratoga St.

MEDICAL CERTIFICATION

18. 3-76 X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO Intestinal obstruction — INTERVAL BETWEEN ONSET AND DEATH: 6 days

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO Peritonitis

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-12-1965 1965 to 5-14-1965, that (I) (we) last saw the deceased alive on 3:25 PM 5-14-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☑	23B. DATE SIGNED
Kyo Rak Lee					May 14, 1965

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Kyo Rak Lee		Franklin Square Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town or county) (State)
Removal	5/18/65	Mt Zion	Margarettville N.C.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 18 1965	Robert E. Faulkner	Marshall Hayes	638 N. Gilmor St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

7-526

65 5256

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5256

1. NAME OF DECEASED (Type or Print): JOTHAM E. TINKER, Jr.

2. DATE AND HOUR PRONOUNCED DEAD: May 6, 1965 4:37 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maine

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rockland

D. STREET ADDRESS (If rural, give location): 70 Thomaston Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White			30				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) DUE TO: Craniocerebral Injury.	
	ANTECENDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO:	
	(C)	
II	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Unknown	Found on lot - 3600 Potee Street

21D. TIME OF INJURY (APPROX.) (Month)	(Day)	(Year)	(Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
Found 5	6	'65	A m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Blunt force injury

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE: Charles Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 5/6/65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/10/65	Mt. Carmel Cem	Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 18 1965	Robert E. Fisher, MD	Joseph M. Zannino	263 S. Conkling St

VS 151-REV. 1/1/65

W-5341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5257 Registered No. 65 5257

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): ANNA WEINDL

2. DATE AND HOUR OF DEATH: 5/16/65 3:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 26-11
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 406 S. BOULDIN ST.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
FEMALE	WHITE	MARRIED	5-5-98	67				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	HOME	BALTO. MD.	USA

13. FATHER'S NAME: JOHN PAULUS

14. MOTHER'S MAIDEN NAME: MARGARET BODNER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—	Hospt. Records.	

MEDICAL CERTIFICATION

18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH: (A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(B) DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Obesity

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/16 3 AM 19 65 to 5/16 3:15 P 19 65, that (I) (we) last saw the deceased alive on MAY 16, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: W. Maddrey M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ — 23B. DATE SIGNED: 5/16/65

23C. PHYSICIAN'S NAME (Type): WILLIS C. MADDREY M.D. — 23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/19/65	New Cathedral	Balto. Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 18 1965	Robert E. Farber M.D.	Joseph N. Zannino	263 S. Conkling

VS 150-REV. 1/1/65

1

P-634

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 65 5258 Registered No. 65 5258

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EDGAR M. PRETLOW

2. DATE AND HOUR PRONOUNCED DEAD: 5-16-65 | 2:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): MERCY HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-01
D. STREET ADDRESS (If rural, give location): 408 E. Biddle Street

37 99

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Colored	Single	10/10/19	45				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Service Station attendant		Va.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edgar Pretlow	Bertha Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Ethel Heartwell - 408 E. Biddle St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fatty infiltration of liver
DUE TO

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): R. Fisher M.D. — RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 5-17-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/20/65	Balto. National Cem.	5501 Frederick Ave

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 18 1965	Robert E. Fahrney	Milton E. Elickson 1129 N. Carlton St

VS 151-REV. 1/1/65

6-500 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5259 Registered No. 65 5259

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) GUNN, VIRGINIA B.

2. DATE AND HOUR OF DEATH 5/16/65 3.55 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion) University Hospitol

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY —
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give locotion) 1301 Madison Ave. 11-64

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	Negro	Widowed	10/22/01	63				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Social Work	Dept. of Rec.	Georgia	U.S.A.

13. FATHER'S NAME William Hodges

14. MOTHER'S MAIDEN NAME Nethia Lyons

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT Gladys Lemert ADDRESS 1640 Ashland Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the diseose, injury or complication which coused deoth.)	
	(A) DUE TO Congestive heart failure	2 hrs.
	(B) DUE TO Obstructive jaundice	5 mos.
	(C) Carcinoma head of pancreas	5 mos.
	ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if ony, giving rise to the above couse (A) stating the UNDERLYING CONDITION lost.	
II	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
5/14/65	Ca head of pancreas	Yes	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exoct locotion)
No		

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospitol) attended the deceased from 5/14/1965 to 5/16/1965, that (I) (we) last saw the deceased olive on 5/16/1965 and thot In(my) (our) opinion deoth occurred on the date ond hour ond from the couses stoted obove. (I) (~~was~~) (did) (~~did not~~) view the body ofter deoth.

23A. SIGNATURE				23B. DATE SIGNED
Carl F. Berner M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	5/16/65

23C. PHYSICIAN'S NAME (Type) CARL F. BERNER M.D. 23D. ADDRESS University Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/19/65	Arbutus Mem. Park	Arbutus Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 18 1965	Robert E. Farley M.D.	Jarrell F. Ellickson	1129 N. Carlton St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-200 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5260 Registered No. 65 5260

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LEWIS, HERBERT (NMI)

2. DATE AND HOUR OF DEATH: 5/13/65 | 7:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
VETERANS ADMINISTRATION HOSPITAL
3900 LOCH RAVEN BLVD
BALTIMORE, MARYLAND 21218

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 9-09
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1331 N. EDEN ST.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
MALE	NEGRO	NEVER MARRIED	4/7/95	69				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
PORTER	JEWELRY STORE	MARYLAND	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
LLOYD, N. LEWIS	MATILDA, FIELDS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
YES 7/15/18 to 6/28/19		VETERANS ADMINISTRATION HOSPITAL RECORDS BALTIMORE, MARYLAND 21218

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Carcinoma of Pancreas — INTERVAL BETWEEN ONSET AND DEATH: 6 months

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cavitary tuberculosis with tuberculous empyema — 2 years

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from Sept. 9, 1964 to May 13, 1965, that (I) (we) last saw the deceased alive on May 13, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Anastacio Hoyumpa M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. X — 23B. DATE SIGNED: 5/14/65

23C. PHYSICIAN'S NAME (Type): Anastacio Hoyumpa M.D.

23D. ADDRESS: VA Hospital, 3900 Loch Raven Blvd. Baltimore, Maryland 21218

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/18/65	Baltimore Natl Cem.	5501 Frederick Ave.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 18 1965	Robert E. Farley, M.D.	Jos. F. Ehlen 1129 N. Carlin St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

43-59-65 AM 1

F-Ldd

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5261 — Registered No. 65 5261

1. NAME OF DECEASED (Type or Print): Betty Fryar

2. DATE AND HOUR OF DEATH: 5-16-65 — 3:55 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY: 12-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2504 Guilford Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	Negro	Married	8-18-1907	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife		North Carolina	U. S. A.

13. FATHER'S NAME: Jimmie Fryar

14. MOTHER'S MAIDEN NAME: Kate King

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		RECORDS: B.C.H.	4940 Eastern Avenue #21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
I 260X	(A) Gram Negative Septicemia	1 Day
	DUE TO (B) Ischiorectal Abscess	?
	DUE TO (C) Diabetes Mellitus	?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Diabetic Ketoacidosis Hypertension and Multiple Cerebral Vascular Accidents.	? Several Years

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-14 19 65 to 5-16 19 65, that (I) (we) last saw the deceased alive on 5-16-65 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
Charles Carpenter					5-16-65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Dr. Charles Carpenter		4940 Eastern Avenue #21224

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/19/65	MT. ZION METHODIST	DELWAY N. C.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 18 1965	Robert E. Farley M.D.	[illegible]	[illegible]

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

272515 1
FR

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5262 Registered No. 65 5262

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Martha Taylor (MARTHA IOLA TAYLOR)

2. DATE AND HOUR OF DEATH: May 14, 1965 | 1:30 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 26-12
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4940 Eastern Avenue 21224

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	Negro	Married	10-5-1894	71				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	HOME	Maryland	U. S. A.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME: HARRIETT

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: RECORDS: BCH 4940 Eastern Avenue 21224 ADDRESS

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Cerebro-Vascular Accident	1 Week
	DUE TO (B) Generalized Arteriosclerotic	Many Years
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. DUE TO Cardio Vascular Disease	
	(C)	
II	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Huntington's Chorea	

MEDICAL CERTIFICATION

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 7, 1960 to May 14, 1965, that (I) (we) last saw the deceased alive on May 14, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J. B. Zachary, M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED: May 14, 1965

23C. PHYSICIAN'S NAME (Type): Dr. James B. Zachary M.D. 23D. ADDRESS: 4940 Eastern Avenue 21224

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	19 May 65	Mt. Calvary	A. A. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 18 1965	Robert E. Farley, M.D.	William S. Carson 1031 Druid Hill Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-366 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5263 Registered No. 65 5263

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Dutterer, Edna Ruthrauff
2. DATE AND HOUR OF DEATH: 5/16/65 — 5 24 M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND
   FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, grve street oddress or locotion): Maryland General Hosp.
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
   A. STATE: Md. B. COUNTY: Carroll
   C. CITY OR TOWN (If outside city limits, write RURAL and give township): Westminster
   D. STREET ADDRESS (If rurol, give locotion): 114 Pennsylvania Ave.
5. SEX: F
6. RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): married.
8. DATE OF BIRTH: 1-14-97
9. AGE (In yeors last birthday): 68 — If Under 1 Yr. Months / Days; If Under 24 Hrs. Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife and florist
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles Ruthrauff.
14. MOTHER'S MAIDEN NAME: Amanda Embry
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Mr Stewart N. Dutterer — ADDRESS: 114 Penna. Ave. Westminster, Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 199.2 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not meon the mode of dying, e.g., heorl foilure, osthenio, etc. It means the diseose, injury or complicotion which coused deoth.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if ony, giving rise to the obove couse (A) stoting the UNDERLYING CONDITION lost.

(A) DUE TO: Carcinomatosis - primary undetermin'd c

(B) DUE TO: hypatic, adrenal cerebral, lymphatic metastasis

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)
21B. PLACE OF INJURY (e.g., in or about home, form, foctory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Boltimore City, give exact locotion)
21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify thot (I) (this hospitol) ottended the deceased from 4-30, 19 65 to 5/16 19 65, thot (I) (we) lost sow the deceosed olive on 5/16 19 65 and thot in (my) (our) opinion deoth occurred on the dote ond hour and from the couses stoted above. (I) (We) (did) (did not) view the body ofter deoth.

23A. SIGNATURE: Nahel Wersal. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 5/16/65
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS: Maryland General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 5/19/65
24C. NAME of CEMETERY or CREMATORY: Westminster Cemetery
24D. LOCATION (City, town, or county) (State): Westminster, Md.

25A. DATE REC'D BY HEALTH DEPT.: MAY 18 1965
25B. NAME OF REGISTRAR: Robert E. Farber M.D.
25C. FUNERAL DIRECTOR: J. E. Myers Jr. — ADDRESS: Westminster, Md.

VS 150-REV. 1/1/65

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65-11668 65 5264 Registered No. 65 5264

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): TERRY LYNN COOK

2. DATE AND HOUR OF DEATH: 5/11/65 8:50 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: (CARROLL COUNTY.)
C. CITY OR TOWN (If outside city limits, write RURAL and give township): WOODBINE ROUTE 1
D. STREET ADDRESS (If rural, give location):

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
FEMALE	~~FEMALE~~ COLORED	NEVER MARRIED	5-11-65				4	10

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: EDWARD

14. MOTHER'S MAIDEN NAME: MARTHA ANN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 763.01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) DUE TO: prolate pneumonia, hyaline membrane disease,

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(B) DUE TO:
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) this hospital) attended the deceased from 5/11 4:45 AM 19 65 to 5/11 19 65, that (I) (we) last saw the deceased alive on 8:45 AM 5/11 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☑	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
John Ey,					5/11/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
DR. JOHN EY.		JHH.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
CREMATION	5-11-65	THE JOHNS HOPKINS HOSPITAL.	601 N. BROADWAY

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 18 1965	Robert E. Faulkner	BALTIMORE, MARYLAND.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-200 1 15 63 59 RS COOK, BABY GIRL 6 11 65

B520 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5265 Registered No. 65 5265

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Nellie Banks
2. DATE AND HOUR OF DEATH: 5-11-65 1:50 P.M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND
   FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Bar-Wil-Ba Convalescent Home
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
   A. STATE: Md. B. COUNTY: 14-02
   C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
   D. STREET ADDRESS (If rural, give location): 1606 Pennsylvania Ave.
5. SEX: F.
6. RACE: Col.
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH:
9. AGE (In years last birthday): 85 (If Under 1 Yr. Months / Days; If Under 24 Hrs. Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George Hill
14. MOTHER'S MAIDEN NAME: Jennie
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: MrsPearl Wright ADDRESS: 1916 McCulloh St

MEDICAL CERTIFICATION

18. 450.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Generalized arteriosclerosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Malnutrition and dehydration

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-3- 1965 to 5-11- 1965, that (I) (we) last saw the deceased alive on 5-11- 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: C.R. Campbell, M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 5-11-65
23C. PHYSICIAN'S NAME (Type): C.R. Campbell M.D.
23D. ADDRESS: 1618 W. North Ave. Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 5/15/65
24C. NAME of CEMETERY or CREMATORY: Mt Calvary Cemetry
24D. LOCATION (City, town, or county) (State): A A County Md

25A. DATE REC'D BY HEALTH DEPT.: MAY 18 1965
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR ADDRESS: Adolphus Halstead 928 Druid Hill Ave

VS 150-REV. 1/1/65

1

5-315

65 5266

BALTIMORE CITY HEALTH DEPARTMENT

65 5266

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOSEPH STEVENS

2. DATE AND HOUR PRONOUNCED DEAD: May 8, 1965 12:10 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 202 Eareckson Place

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-05

D. STREET ADDRESS (If rural, give location): 202 Eareckson Place

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	Indian			81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. 4200

CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease.

DUE TO

ANTECENDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Petty M.D.

EXAMINER'S NAME (Type) Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 5/9/65

ANATOMY BOARD OF MARYLAND

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE MAY 18 1965	23C. NAME of CEMETERY or CREMATORY JOHNS HOPKINS MEDICAL SCHOOL	23D. LOCATION (City, Town, or Co.) (State)

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 18 1965	Robert E. Farley, M.D.	MORTUARY SERVICE - BCHD	

VS 151-REV. 1/1/65

1

5-530

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 5267

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5267

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Algernon L. (Algen) Smith	2. DATE AND HOUR PRONOUNCED DEAD: May 16, 1965 10:00 A M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Bon Secours Hospital	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-04 D. STREET ADDRESS (If rural, give location): 2557 Mc Henry Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Negro	Married	April 27, 1911	54				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Gasburg, Va.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
A. Smith	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes WW II	215-09-6540	Hattie J. Smith	2557 McHenry St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of lung

DUE TO

ANTECENDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		no	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) John E. Adams, M.D. M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED May 16, 1965

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/20/65	Balto National Cem.	Balto., Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 18 1965	Robert E. Fahy, Jr.	Wm C March	928 E. Nobbh Ave.

VS 151-REV. 1/1/65

S-5131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5268 (65 5268)

Registered No. 464,665-2

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Constanee Wade Sanft

2. DATE AND HOUR OF DEATH: May 17, 1965 | 6:50 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 8-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21218
D. STREET ADDRESS (If rural, give location): 2622 Brendan avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
female	White	MARRIED	8-1-00	65				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		MARYLAND	America

13. FATHER'S NAME: Constantine Turner

14. MOTHER'S MAIDEN NAME: Mary Wade

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not meon the mode of dying, e.g., heart foilure, osthenio, etc. It means the diseose, injury or complicotion which coused deoth.)

I 260X

(A) ? CVA

DUE TO

(B) ASCVD

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if ony, giving rise to the above couse (A) stoting the UNDERLYING CONDITION lost.

(C) Diabetes

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol examiner)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exoct locotion)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify thot (I) (this hospitol) ottended the deceased from 5/17 1965 to 5/17 1965, thot (I) (we) lost sow the deceased olive on 5/17 1965 ond thot in (my) (our) opinion death occurred on the dote and hour and from the couses stoted above. (I) (We) (did) (did not) view the body ofter deoth.

23A. SIGNATURE: William B. Long M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED: 5/17/65

23C. PHYSICIAN'S NAME (Type): WILLIAM B. LONG M.D. 23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5-21-65	NEW CATHEDRAL	BALTIMORE. MD

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 18 1965	Robert E. Talbert, M.D.	F.W. OZALEWSKI - 1930 EASTERN AVE

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-5261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

BIRTH NO. 65 5269 Registered No. 65 5269

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): JOSEPH A INCIARDI

2. DATE AND HOUR OF DEATH: 5 16 65 | 12:50P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location): ST AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 29
D. STREET ADDRESS (If rural, give location): 821 S WARWICK RD

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
MALE	WHITE	MARRIED	3 19 01	64				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
VICE EXECUTIVE PRESIDENT	OIL CORP	NEW YORK	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
CHARLES	ROSE RUSSO

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
UNKNOWN		ST AGNES HOSPITAL RECORDS	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA OF URINARY BLADDER — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. HYDRONEPHROSIS (R)

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		YES	YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5 3 19 65 to 5 16 19 65, that (I) (we) last saw the deceased alive on 5 16 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: William A. Dear Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ — 23B. DATE SIGNED: 5-16-65

23C. PHYSICIAN'S NAME (Type): WILLIAM A DEAR, JR M.D. — 23D. ADDRESS:

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-19-65	Loudon Park Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 18 1965	Robert E. Farley, M.D.	Howard H. Hubbard	4107 Wilkens Ave-21229

VS 150-REV. 1/1/65

40-11-75 IB 1
L-550

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5270 Registered No. 65 5270

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): William Lannon (William T. Lannon Sr.)

2. DATE AND HOUR OF DEATH: 5-14-65 | 2:20 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 26 09
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 629 S. EATON ST. #21224

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	11-3-99	65				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Layer-Out	Bethlehem Steel Co.	Maryland	USA

13. FATHER'S NAME: Thomas Lannon

14. MOTHER'S MAIDEN NAME: Catherine Printy

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: RECORDS-BCH-4940 Eastern Avenue #21224 ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
1B. 467.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Chronic Vascular Insufficiency	many years
ANTECEDENT CAUSES	(B) DUE TO	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(C) Chronic Brain Syndrome	many years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Congestive Heart Failure & Atrial Fibrillation	many years

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-8 19 64 to 5-14 19 65, that (I) (we) last saw the deceased alive on 5-14- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
J. B. Zachary,		☐	☐	☒	5-14-65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Dr. James B. Zachary		BCH-4940 Eastern Avenue - #21224

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-17-65	Sacred Heart Cemetery	7401 German Hill Road Balto. 22, Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 18 1965	Robert E. Farley M.D.	Charles L. Zeiler	901 S. Conkling St. #24

VS 150-REV. 1/1/65

W-300 1

BIRTH NO. 65 5271

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5271

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Theodore A. White

2. DATE AND HOUR OF DEATH: May 13, 1965 | 9:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 26-09
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #21224
D. STREET ADDRESS (If rural, give location): 831 S. Conkling St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	Widowed	Dec 16, 1895	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED	BALTO. CITY POLICE.	North Carolina	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Theodore White	Lottie Hutchins

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES W. W. I.	215-32-5885	AGNES G. SCHULER	1224 HILLDALE RD. #6

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
I 422.1	(A) LEFT, C.V.A. DUE TO	
	(B) A.S.C.V.D., Generalized. DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from April 22 1965 to May 13 1965, that (I) (we) last saw the deceased alive on May 13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	23B. DATE SIGNED
L B Tilley	Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒	May 13, 1965

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS M.D.
L. G. Tilley	Maryland General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5-17-65	SACRED HEART CEM.	7401 GERMAN HILL RD., BALTO. CO., MD.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 18 1965	Robert E. Faber M.D.	Charles S. Zeiler 901 S. CONKLING ST. BALTO., 21224, MD.

VS 150-REV. 1/1/65

F-632 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5272 Registered No. 65 5272

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Grace M. Foertschbeck

2. DATE AND HOUR OF DEATH: May 15, '65 | 5:05 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY: [redacted] 26-07
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 319 S. MACON STREET #24

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
FEMALE	WHITE	WIDOWED	8/11/95	69				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HW	AT HOME	Balto., Md	U.S.A.

13. FATHER'S NAME: Joseph Seibert

14. MOTHER'S MAIDEN NAME: Margaret Ritter

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		215-14-7953	JOHN J. FOERTSCHBECK	SAME

MEDICAL CERTIFICATION

18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO: Myocardial Infarction — 19 hrs
(B) DUE TO: Acute Pulm. Edema
(C):

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 14 19 65 to May 15 19 65, that (I) (we) last saw the deceased alive on 4 AM May 15 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
Kyoungho M. Cynn					May 15, '65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
KYOUNGHO M. CYNN	M.D.	Md. General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5- -65.	SACRED HEART CEM.	7401 GERMAN HILL RD. BALTO. CO., MD.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 18 1965	R. L. & E. Fal... M.D.	Charles L. Geiler	6224 EASTERN AVE, BALTO., 21224, MD.

VS 150-REV. 1/1/65

L-25) 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5273 Registered No. 65 5273

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Phillip L. Le Compte

2. DATE AND HOUR OF DEATH: 5/16/65 | 4:45 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital Linden + Madison St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore 21212
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5504 Springlake Way 12

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	married	10-1-04	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sales Mgr.	Bedding Co	Baltimore, Md.	USA

13. FATHER'S NAME: Arthur J. Le Compte

14. MOTHER'S MAIDEN NAME: Rose C. Flood

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 213-03-1327

17. INFORMANT: Hospital Admission Sheet from Wife. ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
I (A)	Bleeding Abd. Aortic Aneurysm	5 Days.
DUE TO (B)	Aortic Aneurysm	6 Wks. Duration
DUE TO (C)	Arteriosclerosis	Unknown.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Post operative cardiac failure	24 hrs.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
5/13/65	Aortic Aneurysm		

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No		

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/13 1965 to 5/16 1965, that (I) (we) last saw the deceased alive on 5/16 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
C. D. Cooksey					5/16/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
C. D. COOKSEY		Maryland General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	5/20/1965	New Cathedral	Baltimore	Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 18 1965	Robert E. Farley M.D.	H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md.

VS 150-REV. 1/1/65

U-532 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

BIRTH NO. M.E. CASE NO. 65 5274 Registered No. 65 5274

1. NAME OF DECEASED (Type or Print): Van Dyke, Hilda S.

2. DATE AND HOUR OF DEATH: 2 38 | 5/16/65 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Mercy Hosp. 37

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 3 B. COUNTY: Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto. Md. 53-00
D. STREET ADDRESS (If rural, give location): 319 Dumbarton Rd

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	M	11/2/1896	68				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	Own Home	Balto. Md.	U.S.A.

13. FATHER'S NAME: George Schluner

14. MOTHER'S MAIDEN NAME: Beatrice Albert

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	If yes, give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		212-22-8375	Wilson J. Van Dyke	(Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not meon the mode of dying, e.g., heart foilure, osthenio, etc. It meons the diseose, injury or complicotion which coused deoth.)

(A) DUE TO: Cerebral insufficiency & injury

(B) DUE TO: Recurrent MI

(C):

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if ony, giving rise to the obove couse (A) stoting the UNDERLYING CONDITION lost.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0	none	no	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Boltimore City, give exoct locotion)

21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this haspital) attended the deceased from ____ 19 ____ to 5/16 19 65, that (I) (we) last saw the deceased alive on 5/14 19 65 and that in (my) (our) opinion death occurred on the date and haur and from the causes stoted above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
David M. Nichols, Jr.					5/16/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
David M. Nichols, Jr. M.D.	Mercy Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/19/1965	Dulaney Valley Mem. Grds.	Cockeysville, Balto. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 18 1965	Robert E. Tenney M.D.	H.W. Jenkins & Sons Co.	4905 York Rd. Baltimore 12, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-346 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5275 Registered No. 65 5275

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Joseph R. Butler

2. DATE AND HOUR OF DEATH: May 13, 1965 | 4:45 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): 5402 Lothian Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 27-48
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5402 Lothian Road

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	Married	Jan. 29, 1917	48				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machinist	Western Elec. Co.	Baltimore, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Roy Lee Butler	Anna S. Borig

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WWII	216-03-9621	Mrs. Hazel N. Butler	(Same)

MEDICAL CERTIFICATION

18. 163 8 I — CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) DUE TO: Carcinoma of both lungs (metastatic) — 10 mo.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(B) DUE TO:
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) ~~(This hospital)~~ attended the deceased from January 19 65 to May 13, 19 65, that (I) (we) last saw the deceased alive on May 11 19 65 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE				23B. DATE SIGNED
Lloyd E. Saylor M.D.	Attending Phys. ☒	Med. Director ☐	Staff Phys. ☐	May 15, 1965

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Dr. Lloyd E. Saylor M.D.	3902 Greenmount Ave.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/17/1965	Dulaney Valley Mem. Grds.	Cockeysville, Balto. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 18 1965	Robt E. Falk, M.D.	H.W. Jenkins & Sons Co.	4905 York Rd. Balto. 12, Md.

VS 150-REV. 1/1/65

B-500 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5276 — Registered No. 65 5276

1. NAME OF DECEASED (Type or Print): Henry E. Bien

2. DATE AND HOUR OF DEATH: May 15, 1965 | M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 0 3214 Ellerslie Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 9-05
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3214 Ellerslie Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	Married	5/18, 1893	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Editor-Retired	News-American	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: Henry C. Bien

14. MOTHER'S MAIDEN NAME: Annie E. Fetzner

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	212-01-7141	Mrs. Marian C. Bien	(Same)

MEDICAL CERTIFICATION

CAUSE OF DEATH

	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	INTERVAL BETWEEN ONSET AND DEATH
I (A) DUE TO	Arteriosclerotic Vascular Disease with Cerebral Vasc. accident	4 yrs.
(B) ~~DUE TO~~	and Squamous Cell Carcinoma right retro	2 3 mos.
(C) ~~DUE TO~~	molar Space	
II	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from July 19 62 to present 19 , that (I) (~~we~~) last saw the deceased alive on 30 April 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (~~did not~~) view the body after death.

23A. SIGNATURE: Arthur G. Siwinski M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐ — 23B. DATE SIGNED: 17 May 65

23C. PHYSICIAN'S NAME (Type): Arthur G. Siwinski M.D. — 23D. ADDRESS: 836 Park Ave.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/19/65	Greenmount	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 18 1965	Robert E. Farley, M.D.	H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-552 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5277 Registered No. 65 5277

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CUNNINGHAM, ANNIE MARY

2. DATE AND HOUR OF DEATH: 5/17/65 | 10:05 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hospital for Women of Md. John & Lafayette; Balto-17 Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY: 6611 MARIETTA AVE
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE - 14, MARYLAND
D. STREET ADDRESS (If rural, give location): 2707

5. SEX: F | 6. RACE: W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED | 8. DATE OF BIRTH: 3/13/85 | 9. AGE (In years last birthday): 80 | If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H.W. | 10B. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): DARLINGTON Md. | 12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: THOMAS BUTLER McATEE | 14. MOTHER'S MAIDEN NAME: MARIA PENELOPE ROBINSON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): UNKNOWN | 16. SOCIAL SECURITY NO.: | 17. INFORMANT: HOSPITAL PATIENT'S CHART. | ADDRESS:

MEDICAL CERTIFICATION

18. 420.0 1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH
(A) Arteriosclerotic heart Disease
DUE TO
(B) + Congestive heart failure
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: | 20A. AUTOPSY? (Yes or No): | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ | 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 5 19 65 to May 17 19 65, that (I) (we) last saw the deceased alive on May 17 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ | 23B. DATE SIGNED: 5-17-65

23C. PHYSICIAN'S NAME (Type): A. MENDOZA M.D. | 23D. ADDRESS: WOMEN'S HOSPITAL, Balto-

24A. BURIAL CREMATION, REMOVAL (Specify): burial | 24B. DATE: 5-20-65 | 24C. NAME of CEMETERY or CREMATORY: Darlington Cemetery | 24D. LOCATION (City, town, or county) (State): Darlington, Md.

25A. DATE REC'D BY HEALTH DEPT.: MAY 18 1965 | 25B. NAME OF REGISTRAR: Robert E. Farley, M.D. | 25C. FUNERAL DIRECTOR ADDRESS: Leonard J. Ruck Inc Baltimore, Md.

VS 150-REV. 1/1/65

A-2561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5278 Registered No. 65 5278

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Carrie E. Heckner

2. DATE AND HOUR OF DEATH: 5-17-65 4:30 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 27-07
C. CITY OR TOWN (If outside city limits, write RURAL and give township): 1936 Sylvan Ave 14
D. STREET ADDRESS (If rural, give location): Baltimore

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	M.	12-11-03	61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Maryland	USA

13. FATHER'S NAME: William R. Hall.

14. MOTHER'S MAIDEN NAME: Knoxie O Foxwell

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	Mr. John E. Heckner	(SAme)

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 162.1

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO: Pulmonary Anetastasis Bilat pneumonic consolidation Pleural effusion?

(B) DUE TO: A.S.C.V.D. - Recurrent Pulm edema effusion

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		—	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/16 19 65 to 5/17/ 19 65, that (I) (we) last saw the deceased alive on ____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: David M. Nichols Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 5/17/65

23C. PHYSICIAN'S NAME (Type): David M. Nichols Jr. M.D.

23D. ADDRESS: Mercy Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/20/65	Asbury Methodist Cem.	Calvert County, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 18 1965	Robert E. Farley, M.D.	Leonard J. Ruck Inc. Balto. 14 Md.

VS 150-REV. 1/1/65

6-150 1

BIRTH NO. 65 5279

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5279

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): ANNA Gavin, Anne A.

2. DATE AND HOUR OF DEATH: May 16 1965 | 9.20PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): St. Joseph Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 8-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21213
D. STREET ADDRESS (If rural, give location): 2219 Kentucky Ave.

41

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
female	white	married	8-17-1918	46		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: John Garrish

14. MOTHER'S MAIDEN NAME: Agnes Ford

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Vincent D. Gavin	(Same)

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Brain abscess, left frontal lobe.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	DUE TO (B)	
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 9 19 65 to May 16 19 65, that (I) (we) last saw the deceased alive on May 16 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
W B VandeGrift M.D.	Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒	May 17, 1965

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
William B. VandeGrift, M.D.	1400 N. Caroline St. Baltimore 21213 Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/20/65	New Cathedral Cemetery	Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 18 1965	Robert E. Talley, M.D.	Leonard J. Ruck Inc. Balto 14 Md.

VS 150-REV. 1/1/65

V-165 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5280 — Registered No. 65 5280

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Rose B. Vavrina

2. DATE AND HOUR OF DEATH: 6:15 AM 5-17-65

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): UNION MEMORIAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2821 GUILFORD AVE 18

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	W	9-9-86	78				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED Balto.	School Teacher	BALTIMORE, Md.	US

13. FATHER'S NAME: Levi Benjamin

14. MOTHER'S MAIDEN NAME: Mollie George Beckwith

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: No

17. INFORMANT: Mr. John R. Hutson — ADDRESS: 2821 Guilford Ave. Baltimore, Maryland 21218

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 199.2 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ~~DUE TO~~ Carcinoma tis, ~~metastases~~

(B) ~~DUE TO~~ Hemorrhagic pancreatitis ~~caused~~

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C) Acute & fat necrosis ARB

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-3-65 19 to 5-17-65 19, that (I) (we) last saw the deceased alive on 5-17-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Francis X. Carmody M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ — 23B. DATE SIGNED: 5-17-65

23C. PHYSICIAN'S NAME (Type): FRANCIS X. CARMODY M.D. — 23D. ADDRESS: Union Memorial Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/20/1965	Greenmount Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	Robert E. Faulkner	Wm. J. Dickman & Sons	Balto. 1, Md. 21217 North & Pa. Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-200 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5281 Registered No. 65 5281

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Minnie Dix

2. DATE AND HOUR OF DEATH: May 17, 1965 | 5 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2211 West Rogers Avenue Methodist Home for the Aged. Baltimore, Maryland 21209

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY 27-15
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2211 West Rogers Avenue 21209

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widowed	9/16/1877	87		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Baltimore, Maryland	

13. FATHER'S NAME: John Andrew Peters

14. MOTHER'S MAIDEN NAME: Annie E. Cole

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-03-7513

17. INFORMANT: Methodist Home for the Aged ADDRESS

MEDICAL CERTIFICATION

18. 445X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Hypertensive cardio vascular

(B) DUE TO: disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 28 February 19 64 to 17 May 19 65, that (I) (we) last saw the deceased alive on 16 May 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John W Barnaby M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 18 May 65

23C. PHYSICIAN'S NAME (Type): JOHN W BARNABY M.D.

23D. ADDRESS: 1531 E North Ave Baltimore Md

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/19/1965	St. Mary's Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	Robert E. Farley, M.D.	Wm. J. Tilmon & Sons	Balto. Md. 21217 North & Pa. Aves.

VS 150-REV. 1/1965

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-163 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5282 Registered No. 65 5282

1. NAME OF DECEASED (Type or Print): Lulu L. Roberts

2. DATE AND HOUR OF DEATH: May 16, 1965 | 11 30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 2211 West Rogers Avenue Methodist Home for the Aged Baltimore, Maryland 21211

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY 27-15
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2211 West Rogers Avenue 9

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widowed	4/20/1886	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Maryland	

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None		Methodist Home for the Aged	

MEDICAL CERTIFICATION

18. 422.1 I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Arteriosclerotic cardio-vascular disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED — While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8 February 1965 to 16 May 1965, that (I) (we) last saw the deceased alive on 16 May 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John W Barnaby M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐ — 23B. DATE SIGNED: 18 May 65

23C. PHYSICIAN'S NAME (Type): JOHN W BARNABY M.D. — 23D. ADDRESS: 1531 E North Ave Baltimore Md

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/19/1965	Oaklawn Cemetery	Essex, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	Robert E. Farber, M.D.	Wm. J. Fichmont & Sons	Balto., Md 21217 North Ave.

VS 150-REV. 1/1/65

C-208 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5283 Registered No. 65 5283

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): VERMONT COOK

2. DATE AND HOUR OF DEATH: MAY 17, 1965 | 12:30 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1728 N. Montford Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 8-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1728 N. Montford Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	COLORED	MARRIED	12-5-1907	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Stock Clerk	Lucas Bros.	Annapolis, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Manser Cook	Estella Carpenter

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	215-09-1821	Marie Cook - 1728 N. Montford Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) DUE TO Bronchogenic Carcinoma of Right Lung	Five Months
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0	Carcinoma of right Lung		

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 6 1965 to May 17 1965, that (I) (we) last saw the deceased alive on May 17 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ✓	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
Marcus W Moore Sr					5/18/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
MARCUS W. MOORE SR.		1371 N. Carey Street Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-20-65	Arbutus Memorial Park	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 19 1965	Robert E. Farley, M.D.	Charles R. Law 802 Madison Ave.

VS 150-REV. 1/1/65

5-5301

BIRTH NO. 65 5284

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5284

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): SMITH, DORSEY.

2. DATE AND HOUR OF DEATH: 5/16/65 — 8³⁰ P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 46 Lutheran Hosp. of Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland. B. COUNTY: 15-47
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore.
D. STREET ADDRESS (If rural, give location): 2316 N. ROSEDALE ST.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male.	Colored	Married	12/25/1907	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Welder	Bethlehem Steel	Weldon, N. C.	U.S.A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James I. Smith	Dora Hawkins

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	237-20-9844	Mary B. wife.	Same.

MEDICAL CERTIFICATION

18. 493 X I — CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonia.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that ☒ (this hospital) attended the deceased from 5/16 1965 to 5/16 1965, that ☒ (we) last saw the deceased alive on 8³⁰ PM 5/16 1965 and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated above. ☒ (We) ☐ (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
S. Rajaee					5/16/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
SOROOSH. RAJAEE. M.D. SOROOSH RAJAEE	Lutheran Hospital of Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-19-65	Arbutus Memorial Park	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 19 1965	Robert E. Farley M.D.	Charles R. Law 802 Madison Ave.

VS 150-REV. 1/1/65

W-308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5285 Registered No. 65 5285

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): MALINDA WYATT

2. DATE AND HOUR OF DEATH: MAY 16, 1965 | M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION: KEYWORTH NURSING HOME
(If not in hospitol or institution, give street oddress or locotion): 2814 KEYWORTH AVENUE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 14-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1612 McCULLOH STREET

90

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	COLORED	MARRIED	MAY 31, 1887	77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE		BALTIMORE, MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
DENNIS WHEELER	MARY WHEELER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		W. THOMAS WYATT	1612 McCULLOH ST.

MEDICAL CERTIFICATION

18. 332 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: Left Cerebral Thrombosis — 1 M 6 D

(B) DUE TO: Generalized Arteriosclerosis — 6 Mos

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-19 1965 to 5-16 1965, that (I) (we) last saw the deceased alive on 5-16 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: G. Franklin Phillips M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐ — 23B. DATE SIGNED: 5/19/65

23C. PHYSICIAN'S NAME (Type): G. Franklin Phillips M.D. — 23D. ADDRESS: 558 McMechen St. Balto. Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5-20-65	MT. AUBURN CEMETERY	BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 19 1965	Robt E. Talbert	CHARLES R. LAW - 802 MADISON AVE.

VS 150-REV. 1/1/65

R-125 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5286 Registered No. 65 5286

1. NAME OF DECEASED (Type or Print): Marie Robison

2. DATE AND HOUR OF DEATH: May 16, 1965 | 1 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): 1443 Henry St.

4. USUAL RESIDENCE (Where deceosed lived. If institution: residence before odmission)
A. STATE: Maryland B. COUNTY: 24-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rurol, give locotion): 1443 Henry St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In yeors lost birthdoy)	If Under 1 Yr. Months / Doys	If Under 24 Hrs. Hours / Min.
Female	White	Widow	April 27, 1901	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Balto. Md.	U S A

13. FATHER'S NAME: James H. Burns

14. MOTHER'S MAIDEN NAME: Catherine A. Mc Parland

15. Wos Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give wor or dotes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Mrs. Margaret M. Burns	1419 Henry St.

MEDICAL CERTIFICATION

18.	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 593X 260X	(A) DUE TO: Bright's disease	7 more years
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above couse (A) stating the UNDERLYING CONDITION last.	(B) DUE TO:	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	General arteriosclerosis Diabetes Mellitus	years 10 more years

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
none		no	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or obout home, form, loctory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Boltimore City, give exoct locotion)
no		

21D. TIME OF INJURY (APPRDX.) (Month) (Doy) (Yeor) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from March 4, 1965 to May 16, 1965, that (I) (~~we~~) last saw the deceased alive on May 15, 1965 and that in(my) (~~our~~) opinlan death occurred on the date and haur and fram the causes stated above. (I) (~~We~~) (did) (~~did not~~) vlew the body after death.

23A. SIGNATURE		23B. DATE SIGNED
C. Chiu M.D.	Attending Phys. ☒ Med. Director ☐ Stoff Phys. ☐	5-16-65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Chi-Chao Chiu M.D.	1 E. Randall Street, Baltimore, Md. 21230

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5 20 65	New Cathedral	Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	Robert E. Fahey M.D.	Mc Cully	130 E. Fort Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

T-425

K 400

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 5287

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5287

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EMMA TILGHMAN (KELLEY)

2. DATE AND HOUR PRONOUNCED DEAD: 5-17-65 9:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION: FRANKLIN SQUARE HOSPITAL
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-02
D. STREET ADDRESS (If rural, give location): 1031 W. Lexington Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	Negro	Married	Aug- 3, 1921	43		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Magothy, A.A. Co., Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William O. Banks	Tennie Banks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Tennie Banks	1031 W. Lexington St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

422.1 + 260X

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic cardiovascular disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(B)
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Diabetes mellitus

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: John E. Adams M.D.
EXAMINER'S NAME (Type): John E. Adams, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 5-18-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5-22-65	Mt. Zion Methodist Cem.	Magothy Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	Robert E. Faulkner M.D.	Norton & Ogett F.H.	1701 Laurens St.

VS 151-REV. 1/1/65

V-5251

BIRTH NO. 65 5288

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5288

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Gladys Johnson

2. DATE AND HOUR OF DEATH: 5-17-65 | 6:25 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 17-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 812 Edmondson Ave #1.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	N.	Single.	11-5-19	45				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Franklin Douglas.
14. MOTHER'S MAIDEN NAME: Mary Johnson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Mamie Sawyer ADDRESS: 812 Edmondson Ave

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Acute Gastric Dilatation DUE TO	Hours.
ANTECEDENT CAUSES	(B) Gangrenous Obstructed DUE TO Small Intestine.	0 —
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(C) Cerebral Thrombosis	YEARS.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	ASCVND & mild C.H.F.	

MEDICAL CERTIFICATION

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
—	—	Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from 5-13 19 65 to 5-17 19 65, that ~~I~~ (we) last saw the deceased alive on 5-17 19 65 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~I~~ (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Robert Dyke M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED: 5-18-65

23C. PHYSICIAN'S NAME (Type): M.D. 23D. ADDRESS:

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-22-65	Mount Auburn	Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.: MAY 19 1965 25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: The Upton & Dyett Funeral Home ADDRESS: 1701 Laura

VS 150-REV. 1/1/65

+-341 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5289 Registered No. 65 5289

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HANNAH Teitelbaum

2. DATE AND HOUR OF DEATH: 5-17-65 12 30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): Sinai Hospital of Balto

4. USUAL RESIDENCE (Where deceosed lived. If institution: residence before odmission)
A. STATE: MARYLAND B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00
D. STREET ADDRESS (If rurol, give locotion): 3434 Lynne Haven Dr. 7

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In yeors . lost birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	M	8-6-21	49				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): POLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ISRAEL
14. MOTHER'S MAIDEN NAME: GOLDA

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JACOB TEITELBAUM — ADDRESS: Same

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18.	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	
(A) DUE TO	Malignant hypertension + Cerebral Hemorrhage	3 days
(B) DUE TO	Chronic and acute renal failure	5 mos
(C)	Chronic pyelonephritis	20 yrs
	ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the obove cause (A) stating the UNDERLYING CONDITION last.	
II	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None	

MEDICAL CERTIFICATION

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer) NO
21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exoct locotion)
21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour):
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify thot (I) (this hospital) attended the deceosed from 5-6- 19 65 to 5-17 19 65, thot (I) (we) lost sow the deceased olive on 5-17 19 65 ond thot in (my) (our) opinion death occurred on the dote and hour ond from the couses stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: H-Gerard Osten M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 5/17/65
23C. PHYSICIAN'S NAME (Type):
23D. ADDRESS: Sinai Hospital of Balto

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	5/18/1965	Wash Blvd	Balto	MD

25A. DATE REC'D BY HEALTH DEPT.: MAY 18 1965
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Sylvan S. Lewis & Son, Inc — ADDRESS: 3319 Olympic Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-260 1

BIRTH NO. Elkton, Md 65 5290

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 5290

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print)	Baby of Baker. TWIN "A"
2. DATE AND HOUR OF DEATH	5-17-65 | 3.20 A M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion)	THE JOHNS HOPKINS HOSPITAL
4. USUAL RESIDENCE (Where deceosed lived. If institution: residence before odmission) A. STATE B. COUNTY	DELAWARE
C. CITY OR TOWN (If outside city limits, write RURAL ond give township)	MIDDLETON V-07
D. STREET ADDRESS (If rurol, give locotion)	POST OFFICE BOX 149
5. SEX	FEMALE
6. RACE	WHITE
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	NEVER MARRIED
8. DATE OF BIRTH	5-16-65
9. AGE (In yeors lost birthdoy) If Under 1 Yr. Months / Doys / If Under 24 Hrs. Hours / Min.	9
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (Stote or foreign country)	
12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME	WILLIAM S. BAKER
14. MOTHER'S MAIDEN NAME	PATRICIA ANN SCOTT
15. Wos Deceosed Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give wor or dotes of service)	
16. SOCIAL SECURITY NO.	
17. INFORMANT / ADDRESS	

MEDICAL CERTIFICATION

18. 773.01

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not meon the mode of dying, e.g., heort failure, asthenio, etc. It meons the disease, injury or complicotion which coused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if ony, giving rise to the above couse (A) stoting the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO: Hyaline Membrane Disease. — INTERVAL BETWEEN ONSET AND DEATH: 9 hours.

(B) DUE TO:

(C):

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or obout home, form, foctory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Boltimore City, give exoct locotion)
21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify thot (I) (this hospitol) ottended the deceosed from 5/14 10:30pm 1965 to 5/17 5:20pm 1965, thot (I) (we) lost sow the deceased olive on 5/17 1965 ond thot in (my) (our) opinion deoth occurred on the dote ond hour ond from the couses stoted above. (I) (We) (did) (did not) view the body ofter deoth.

23A. SIGNATURE	John Ey	M.D. Attending Phys. ☑ Med. Director ☐ Stoff Phys. ☐	23B. DATE SIGNED 5/17/65
23C. PHYSICIAN'S NAME (Type)	JOHN EY	M.D.	23D. ADDRESS JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
CREMATION	5-17-65,	JHH 601 N. BROADWAY.	BALTIMORE,	MD.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	Robert E. Farley, M.D.		

VS 150-REV. 1/1/65

B-260 1

BIRTH NO. Elkton, Md. 65 5291

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X Registered No. 65 5291

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): BABY BOY "B" BAKER

2. DATE AND HOUR OF DEATH: 5-17-65 | 12.15A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: DELAWARE
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): MIDDLETON V-07
D. STREET ADDRESS (If rural, give location): POST OFFICE BOX149

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
MALE	WHITE	NEVER MARRIED	5-16-65				5	15

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: WILLIAM S. BAKER

14. MOTHER'S MAIDEN NAME: PATRICIA ANN SCOTT

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. 762.01

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: 1° ADENCA CAUS UNKNOWN

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO: Hyaline Membrane Disease

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10 3/pm 5/16 19 65 to 12 5/17 19 65 Am, that (I) (we) last saw the deceased alive on 5/17 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
John Ey		✓	☐	☐	5/17/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
JOHN EY		JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
CREMATION.	5-17-65	JHH 601 N. BROADWAY,	BALTIMORE, MD.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 18 1965	Robert E. Parker, M.D.		

VS 150-REV. 1/1/65

B-6501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65-1222965 5292 Registered No. 65 5292

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Baby ? BROWN

2. DATE AND HOUR OF DEATH: 5/17/65 | 250 AM. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 15-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1710 N. BENTALOU STREET

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
FEMALE	NEGRO	NEVER MARRIED	5-16-65				16	20

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ELATAS- ?

14. MOTHER'S MAIDEN NAME: PHYLLIS ANNBROWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

1B. 760.01

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: ASPIRATION GASTRIC CONTENTS

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO: INTRACRANIAL HEMORRHAGE

(C)

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPRDX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/16 19 65 to 5/17 19 65, that (I) (we) last saw the deceased alive on 5/17 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
John Ey		☒	☐	☐	5/17/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
JOHN EY		JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
CREMATION	5-17-65	JHH 601 N.	BROADWAY, BALTIMORE, MD.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 19, 1965	Robert E. Fahey, M.D.		

VS 1S0-REV. 1/1/65

1

C-445

BALTIMORE CITY HEALTH DEPARTMENT

65 5293

BIRTH NO. 65 5293 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Helen R. Cleland	2. DATE AND HOUR PRONOUNCED DEAD: May 15, 1965 | 10:45 P M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 42 Sinai Hospital	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21220 D. STREET ADDRESS (If rural, give location): 7238 Park Heights Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	WIDOWED	3/25/1908	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	AT HOME	NEW YORK	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
LOUIS COHEN	BERTHA RICHMOND

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO		MR. JOE KOWINS 6609 REISTERSTOWN ROAD

MEDICAL CERTIFICATION

E 971.8

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Overdose of barbiturate and chloral hydrate

ANTECENDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO:

(C):

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		yes	yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Home	7238 Park Heights Avenue

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
Found: 5 15 65 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Ingested overdose of barbiturate and chloral hydrate

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type): John E. Adams M.D.

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: May 16, 1965

23A. BURIAL, CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county)	(State)
Cremation	5/17/65	~~LORRAINE PARK MAUSOLEUM~~ Loudon Park K	BALTIMORE	MARYLAND

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	Robert E. Falkey M.D.	SOL LEVINSON & BROS. INC.	6010 REISTERSTOWN RD

E 974.0

VS 151-REV. 1/1/65

D-3201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.
M.E. CASE NO. 65 5294

Registered No. 65 5294

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): DEITZ, CLARA

2. DATE AND HOUR OF DEATH: 5/16/65 | 11:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddiess or locotion): Sinai Hospital of Baltimore, Inc.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before odmission)
A. STATE: Maryland B. COUNTY: 27-17
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2511 Oakley Ave # 15

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	MARRIED	12/20/1907	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CLERK	HOSPITAL	Baltimore, Maryland	USA

13. FATHER'S NAME: William Cohen

14. MOTHER'S MAIDEN NAME: Esther ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	—	HOSPITAL RECORD	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) RHEUMATIC HEART DISEASE — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
—	—	YES	NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from 5/16 19 65 to 5/16 19 65, that (I) (we) last saw the deceased alive on 5/16 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☑	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
Dr Bernard J Cohen					5/17/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
BERNARD J. COHEN		Sinai Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/18/65	HEBREW YOUNG MEN	BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	Robert E. Foulke, M.D.	S. L. Levinson & Bros. Inc.	6010 Reisterstown Rd

VS 150-REV. 1/1/65

K-6101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO. 65 5295

Registered No. 65 5295

1. NAME OF DECEASED (Type or Print) Sarah Kroop

2. DATE AND HOUR OF DEATH 5/15/65 11:49 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location)

42 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE md B. COUNTY Balto. Balto

C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto ? 5300

D. STREET ADDRESS (If rural, give location) 3815 Southern Cross Drive

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	W. dowed	6/8/94	70				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Russia	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		216-22-7817	Mr. Samuel Press	3423 Lynne Haven Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not meon the mode of dying, e.g., heort failure, asthenia, etc. It meons the disease, injury or complicotion which caused death.)

(A) DUE TO myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs or less

(B) DUE TO HASCVD — 7-8 Years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if ony, giving rise to the above cause (A) stoting the UNDERLYING CONDITION lost.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
—	—	Yes	no

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
no	—	—

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?
—	—	—

22. I certify thot (I) (this hospitol) ottended the deceosed from 5/15/65 19 to 5/15/1965, thot (I) (we) lost sow the deceased alive on 5/15/19 65 ond that In (my) (our) opinion death occurred on the date ond hour ond from the couses stoted above. (I) (We) (did) (did not) view the body ofter deoth.

23A. SIGNATURE		23B. DATE SIGNED
Richard Gerald Shugarman, M.D.	Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐	5/15/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Richard Gerald Shugarman, M.D.	Sinai

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/16/1965	Petach Tikvah Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 18 1965	Robert E. Farley, M.D.	Sol Levinson & Bros.	6010 Reisterstown Rd.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5296 Registered No. 65 5296

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): KATZ, William.

2. DATE AND HOUR OF DEATH: 5/16/65 5:00 a. M.

3. PLACE OF DEATH (IN BALTIMORE, MARYLAND)
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 19 North Charles General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 27 16 mE.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 3405 DUPONT AVE.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male.	White.	WIDOWED	May 15, 1897	67				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
PRESSER RETIRED		Russia.	AMERICAN.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
KATZ Hyman.	Dorothy.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.	212-01-8484	MRS. IRENE Feldman	Cherry Hill Rd

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I 4 20 1
(A) Myocardial Infarction
DUE TO
(B) Arteriosclerotic Cardio-
DUE TO
(C) Vascular Disease.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/12/65 1965 to 5/16/65 1965; that (I) (we) last saw the deceased alive on 5 a.m. 5/16/65 1965. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☑	23B. DATE SIGNED
Anselmo M. Alligood					5/16/65.

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
ANSELMO M. ALLIGOOD		North Charles General Hospital.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	5/17/65	Mishkan Israel	Baltimore	Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	Robert E. Farley M.D.	L. Levenson & Bro.	Baltimore

VS 150-REV. 1/1/65

M-625 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5297 Registered No. 65 5297

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): MERSON IRVING (ISHOORE)

2. DATE AND HOUR OF DEATH: 9 2c pm 01/15/65 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
90 Belvedere Nursing Home
2525 W. Belvedere Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY 11-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 705 St. Paul Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	4/12/1894	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Employee	Show Business	Russia	Usa

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	W. W. I Army		Mrs. Harriet Merson	2417 Lightfoot Drive.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
I (A) DUE TO	Emphysema	15 yr.
(B) DUE TO #1	Chronic bronchopneumonia	5 yr.
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	arteriosclerotic C.V.D.	

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1946 19 to 15 May 19 65, that (I) (~~we~~) last saw the deceased alive on 15 May 19 65 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☑	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
Jack B Gross					May 15 1965

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
6911 Park Heights Avenue		6911 Park Heights Ave Balto Md

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/16/1965	Chizuk Amuno Cemeterby	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 18 1965	Robert E. Farley, M.D.	Sol Levinson & Bros.	6010 Reisterstown RD.

VS 150-REV. 1/1/65

W 7452 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5298 Registered No. 65 5298

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): WILLIAMS THOMAS

2. DATE AND HOUR OF DEATH: 5/16/65 — 5:50 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): University Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 16-AD
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21216
D. STREET ADDRESS (If rural, give location): 1409 N. ROSEDALE ST.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	N	Widowed	11/24/96	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CEMENT FINISHER	—	S.C.	USA

13. FATHER'S NAME: Gordan Williams

14. MOTHER'S MAIDEN NAME: Elizabeth ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: HOSPITAL RECORD ADDRESS

MEDICAL CERTIFICATION

18. 491XH023X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

(B) DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C) BRONCHOPNEUMONIA of Rt & Rt Lo LOBES
POSSIBLE UNDERLYING CANCER

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. JAUNDICE PROBABLY 2° to CIRRHOSIS + SYPHILITIC AORTITIS

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/10/65 19 to 5/16/65 19, that (I) (we) last saw the deceased alive on 5/16/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: L. Bradley Baker, M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 5/16/65

23C. PHYSICIAN'S NAME (Type): L. BRADLEY BAKER, M.D.

23D. ADDRESS: UNIVERSITY HOSPITAL.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/19/65	Mt. Auburn Cem.	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	Robert E. Yates	Rayner Sanders	217 E. Preston St.

VS 150-REV. 1/1/65

J 2501

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5299 — Registered No. 65 5299

1. NAME OF DECEASED (Type or Print): JAMES JACKSON
2. DATE AND HOUR OF DEATH: 5/17/65 — 5:30 A M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND
   FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location): UNIVERSITY HOSPITAL
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
   A. STATE: MARYLAND — B. COUNTY: 25-32
   C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21225
   D. STREET ADDRESS (If rural, give location): 1101 SLATER Rd.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	Negro	married	12/31/09	55		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chauffeur Helper	Trucking	Md., Baltimore	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
OTHEO JACKSON	RUTH WILL

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	213-05-2869	HOSPITAL RECORD	

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Chronic Brain Syndrome	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	DUE TO (B)	
	DUE TO (C) Old Head injury (years ago)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Fever of unknown etiology	

E 962.1

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
5/6/65	TO R/O tumor, or subdural bleeding	NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
not recent	?	? 00-00

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
1945 or 1947	While At Work ☐ ? Not While At Work ☐	?

22. I certify that (I) (this hospital) attended the deceased from 4/30 19 65 to 5/17 19 65, that (I) (we) last saw the deceased alive on 5/17/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	23B. DATE SIGNED
L. Bradley Baker	Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑	5/17/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS M.D.
L. BRADLEY BAKER	UNIVERSITY HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/20/65	Arbutus Memorial Pk.	Baltimore Co. Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 19 1965	Robert E. Farley M.D.	Herbert E. Nutter-3035 W. North Ave

VS 150-REV. 1/1/65

1

B 346

BIRTH NO. 65 5300

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5300

1. NAME OF DECEASED (Type or Print): (Carrie) VIRGINIA BUTLER

2. DATE AND HOUR PRONOUNCED DEAD: 5-17-65 12:05 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): JOHNS HOPKINS HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 6-03
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 207 N. Broadway

37
99

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	Colored	Widowed	3/6/1919	46				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Clark County, Virginia	U.S.A

13. FATHER'S NAME: Charles Mason

14. MOTHER'S MAIDEN NAME: Hattie Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	---	William M. Wright	2202 Park Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary embolism with secondary thrombosis

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE R R Fisher M.D.

EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 5-17-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/20/65	Orrick Cemetery	Winchester, Virginia

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	R. L. & F. Funeral	Herbert E. Nutter	3035 W. North Ave

VS 151-REV. 1/1/65

42-26-42 AM
N-655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5301
M.E. CASE NO.
Registered No. 65 5301

1. NAME OF DECEASED (Type or Print): Clarence Edward Norman
2. DATE AND HOUR OF DEATH: 5-17-65 | 11:42 A.M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or locotion): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland #21224
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rurol, give locotion): 2706 Giles Road #21225

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	Negro	Married	10-27-1922	42		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Shipping Clerk		Virginia	U. S. A.

13. FATHER'S NAME: Lunsford Norman
14. MOTHER'S MAIDEN NAME: Hattie Saundra

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Noami Norman	RECORDS: B. C. H. 4940 Eastern Avenue #24

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the diseose, injury or complicotion which coused deoth.)	(A) Tuberculosis	2 Years
	DUE TO (B)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if ony, giving rise to the obove cause (A) stoting the UNDERLYING CONDITION lost.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

MEDICAL CERTIFICATION

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Boltimore City, give exoct location)
21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify thot (I) (this hospitol) ottended the deceosed from 11-30-64 1964 to 5-17 1965, that (I) (we) last sow the deceased alive on 5-17- 1965 ond thot in (my) (our) opinion deoth occurred on the dote ond hour ond from the causes stoted obove. (I) (We) (did) (did not) view the body ofter deoth.

23A. SIGNATURE		23B. DATE SIGNED
Dr. Richard A. Lane M.D.	Attending Phys. ☐ Med. Director ☐ Stoff Phys. ☒	5-17-65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Dr. Richard A. Lane M.D.	4940 Eastern Avenue #21224

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-21-65	Mt Calvary	Brooklyn A. A. co. Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	R. Earl E. Fisher, M.D.	Burnell C. Alden - Sale. Md.	

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L526 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

BIRTH NO. 65 5302 Registered No. 65 5302

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Lily May Langer

2. DATE AND HOUR OF DEATH: 5/17/65 | 2:15 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Union Memorial Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Kingsville 5370
D. STREET ADDRESS (If rural, give location): Miller Rd. Rt 1 Box 177

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	Wid	7/21/00	64				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Baltimore	USA

13. FATHER'S NAME: Amos Clayton

14. MOTHER'S MAIDEN NAME: Theodate Knoff

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		daughter - Myrtle Alverson	Same

MEDICAL CERTIFICATION

18. 422.1 + 260X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the diseose, injury or camplication which coused deoth.)

(A) Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: hrs.

DUE TO

(B) Acute Myocardial Infarction

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C) ASCVD

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Diabetes Mellitus

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/16 11:15a pm 19 65 to 5/17 2:15 pm 19 65, that (I) (we) last saw the deceased alive on 5/17 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Miriam R. Cohen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 5/17/65

23C. PHYSICIAN'S NAME (Type): MIRIAM R. COHEN M.D.

23D. ADDRESS: Union Memorial Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/20/65	Baltimore Cemetery	Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 19 1965	Robert E. Faherty	Henry Sander & Sons Inc. Baltimore-Maryland 21213

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V 4631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5303 Registered No. 65 5303

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mr. Louis Antoine Villard

2. DATE AND HOUR OF DEATH: 5/18/65 | 905 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: PENNSYLVANIA B. COUNTY: — V-35
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BETHLEHEM
D. STREET ADDRESS (If rural, give location): Essex House 1825 CENTER ST.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	3/14/97	68				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	V.P. of Bethlehem Fabricators	Patterson, N.J.	U.S.A.

13. FATHER'S NAME: Theophile Villard

14. MOTHER'S MAIDEN NAME: Antoinette Buchanan

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): UNK

16. SOCIAL SECURITY NO.: 171-09-1383

17. INFORMANT: Wife: (Gladys Villard) ADDRESS: Essex House, Bethlehem, Penna. SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
I (A)	Cerebral Thrombosis	11 days
DUE TO (B)	Cerebral Arteriosclerosis	10 years
DUE TO (C)	Diabetes Mellitus	8-10 years
II	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION: 0 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: | 20A. AUTOPSY? (Yes or No): No | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ | 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 5/17 19 65 to 5/18 19 65, that (I) (~~we~~) last saw the deceased alive on 5/18 19 65 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: William N. Bennett M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ | 23B. DATE SIGNED: 5/18/65

23C. PHYSICIAN'S NAME (Type): WILLIAM N. BENNETT William N. Bennett M.D. | 23D. ADDRESS: Union Memorial Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/21/65	Niskey Hill Cemetery	Bethlehem, Penna.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 19 1965	Robert E. Farley, M.D.	Stewart & Mowen Co., 108 W. North Av., City

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R453 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5304 Registered No. 65 5304

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Lydia Sulzer Ruland

2. DATE AND HOUR OF DEATH: May 17, 1965 | 10:35 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48 Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY: 9-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 3706 Old York Rd.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Widow	Prob 7/22/86 1887	prob 78 77				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE	NONE	XXXXXX NEW YORK	

13. FATHER'S NAME: Julius Sulzer

14. MOTHER'S MAIDEN NAME: Sophia "unknown last name"

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: son	ADDRESS
NO	217-05-3951	Mr. Louis J. Ruland,	Buckingham, Balto. Road 21207

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Carcinomatosis	8 Mos.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

MEDICAL CERTIFICATION

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No.	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 11 1965 to May 17 1965, that (I) (we) last saw the deceased alive on 10 30 PM 5/17 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
Kyoungho M. Cynn					May 17, 65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Kyoungho M. Cynn		Md. General Hosp

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/20/65	Cathedral Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	Robert E. Faikyma	Stewart & Mowen Co.,	108 W. North Av., City 21201

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P362 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. (2) 65 5305 Registered No. 65 5305

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Charles Louis Peters

2. DATE AND HOUR OF DEATH: May 16/65 | M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitel er institution, give street oddress or lecotion): 35 S. Stricker St.

4. USUAL RESIDENCE (Where deceased lived. If institutien: residence before edmission)
A. STATE: Md. B. COUNTY: 9-03
C. CITY OR TOWN (If outside city limits, write RURAL end give tewnship): Baltimore 23
D. STREET ADDRESS (If turol, give locetien): 35 S. Stricker St

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In yeors lest birthdey)	If Under 1 Yr. Months / Deys	If Under 24 Hrs. Heurs / Min.
Male	White	Single	June 20/91	73		

10A. USUAL OCCUPATION (Give kind of work dene during mest of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State er fereign ceuntry)	12. CITIZEN OF WHAT COUNTRY?
		Balto. Md	USA

13. FATHER'S NAME: Jacob Peters

14. MOTHER'S MAIDEN NAME: Frances---

15. Wes Deceased Ever in U. S. Armed Ferces? (Yes, ne er unknewn) (If yes, give wor or detes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	218 07 6134	Wm.S.Smith,	227 S.Vincent st, Balto. 23

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not meon the mode of dying, e.g., heart foilure, osthenia, etc. It meons the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if ony, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes er No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicel exeminer)	21B. PLACE OF INJURY (e.g., in er about home, ferm, foctory, street, effice bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exoct locetien)

21D. TIME OF INJURY (APPROX.) (Menth) (Dey) (Yeer) (Heur)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Werk ☐	

22. I certify that (I) (this hospital) attended the deceased from Dec. 19 64 to May 16 19 65, that (I) (we) last saw the deceased alive on May 10, 65 19 and that in (my) (our) opinion death occurred on the dote and hour and from the causes stated above. (I) (We) ~~did~~ (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☒	Med. Director ☐	Steff Phys. ☐	23B. DATE SIGNED
Morris B. Schreiber					5-18-65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
MORRIS B. SCHREIBER		1519 W. Lombard St.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, tewn, er county) (Stete)
burial	5/19/65	Loudon Park	Balto. 29, Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	Robert E. Farley, M.D.	Witzke F.D.	4101 Edmondson Ave

VS 150-REV. 1/1/65

V-360 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5306 Registered No. 65 5306

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JAMES GARRITY JETER

2. DATE AND HOUR OF DEATH: May 18, 1965 10:15 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Public Health Service Hospital Wyman Pk. Drive & 31st Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 5-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1806 Lorman Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	colored	Married	11/9/15	49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Morgan Jeter	Emma ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	220-03-2315	Records- US PHS Hospital	Balto, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Asphyxia secondary to sanginous aspiration — Interval: Terminal

(B) DUE TO: Squamous cell carcinoma of soft palate — Interval: 1 yr.

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		yes	yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec. 29 19 64 to May 18 19 65, that (I)/(we) last saw the deceased alive on May 18 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: A. Lupovitch M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ — 23B. DATE SIGNED: 5/18/65

23C. PHYSICIAN'S NAME (Type): Aaron Lupovitch, Surgeon (R) M.D. — 23D. ADDRESS: US PHS Hospital, Balto, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-21-65	Mt Auburn Cem.	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	Robert E. Farley, M.D.	George A. Kelson	1378 N. Calhoun St.

VS 150-REV. 1/1/65

RGB

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1-520 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65-11001 65 5307 Registered No. 65 5307 4

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Baby Boy B (Jones.)

2. DATE AND HOUR OF DEATH 5-9-65 6 PM. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location) Lutheran Hospital of M.D.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY 16-07
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3030 Belmont Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
MALE	NEGRO		5/9/65				0	22

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
			USA

13. FATHER'S NAME WILLIAM J. HOES

14. MOTHER'S MAIDEN NAME DOLORES GRAY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

18. 776 X 1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO Immaturity. — INTERVAL BETWEEN ONSET AND DEATH: 22 MINS

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-9-65 6 PM 1965 to 5-9-65 6 PM 1965, that (I) (we) last saw the deceased alive on 5-9-65 6 PM 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE milani M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ — 23B. DATE SIGNED 5/9/65

23C. PHYSICIAN'S NAME (Type) MOKHTAR MILANI M.D.

23D. ADDRESS ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town or county) (State)
	MAY 17 1965		

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 19 1965	Robert E. Faber M.D.	MORTUARY SERVICE - BOARD

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

B-560

46/99

65 5308

BALTIMORE CITY HEALTH DEPARTMENT

65 5308

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ALPHONSO BONNER

2. DATE AND HOUR PRONOUNCED DEAD: 5-16-65 11:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): LUTHERAN HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-06
D. STREET ADDRESS (If rural, give location): 726 Poplar Grove Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male,	Colored			74				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 216-09-1636

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. 422.1 I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) DUE TO: Arteriosclerotic cardiovascular disease	
ANTECENDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO:	
	(C)	
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type): R. S. Fisher M.D. RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 5-17-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5-20-65	Mt Auburn Cemetery	Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	Robert E. Farley M.D.	C. Wainwright	2700 Edmondson Ave.

VS 151-REV. 1/1/65

42-39-04 IB 1

F645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5309 — Registered No. 65 5309

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Roger Freeland

2. DATE AND HOUR OF DEATH: 5-13-65 — 2:40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland-21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY: Maryland - Calvert
C. CITY OR TOWN (If outside city limits, write RURAL and give township): RURAL - Prince Frederick
D. STREET ADDRESS (If rural, give location):

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Negro	Married	6-30-13	51				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Labor		Maryland	USA

13. FATHER'S NAME: Isiah Freeland

14. MOTHER'S MAIDEN NAME: Mary Chew

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	214-28-9190	RECORDS-BCH-4940 Eastern Avenue - #21224	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Carcinoma of Prostate with Multiple Metastases	1963
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(B) DUE TO	
	(C)	
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from 12-16 1964 to 5-13 1965, that (I) (we) last saw the deceased alive on 5-13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: C. J. Carpenter M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ — 23B. DATE SIGNED: 5-13-65

23C. PHYSICIAN'S NAME (Type): Dr. Charles Carpenter M.D. — 23D. ADDRESS: 4940 Eastern Avenue - #21224

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
X	5-18-65	Patuxent Church-Cem.	Huntingtown	Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	Robert E. Faulkner	P. E. Sewell	Prince Frederick Md.

VS 150-REV. 1/1/65

1

H-625

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 5310

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5310

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HARVEY PAUL HARRIGAN

2. DATE AND HOUR PRONOUNCED DEAD: 5-17-65 11:48 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): SOUTH BALTIMORE GENERAL HOSPITAL-DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Virginia
B. COUNTY: V-43
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Leesburg
D. STREET ADDRESS (If rural, give location): 7 Union Street

43/99

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Never Married	12-16-1925	39				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Religious		Washington, D.C.	U.S.A.

13. FATHER'S NAME: George Peter Harrigan

14. MOTHER'S MAIDEN NAME: Ethel M. Jarboe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Ethel M. Harrigan	3130 V Place S.E. Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

E 981X 1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Shotgun wound of the back

DUE TO

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Apartment	Second Floor 1308 Light Street

21D. TIME OF INJURY (APPROX.) (Month)	(Day)	(Year)	(Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
5	17	'65	m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Shot in back

22. I certify that I held on Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE: Russell S Fisher M.D.

EXAMINER'S NAME (Type): RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER [X]
ASSISTANT MEDICAL EXAMINER [ ]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 5-17-65

23A. BURIAL ~~CREMATION~~, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/19/65	Mt. Olivet Cemetery	Washington D.C.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 19 1965 Roberts	E. Farber M.D.	Robert A Mattingly

VS 151-REV. 1/1/65

N 836.4

5-5201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65-13534 65 5311 Registered No. 65 5311

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Long, Baby Boy.

2. DATE AND HOUR OF DEATH: 5/14/65 | 6:12 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location): MERCY HOSP

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: 1205
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO
D. STREET ADDRESS (If rural, give location): 1628 N. CHARLES ST.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	Can		5/13/65				33	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		MD.	

13. FATHER'S NAME: DARL

14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO			DARL LONG.	1628 N CHARLES ST.

MEDICAL CERTIFICATION

18. 7266 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH
(A) DUE TO: Immaturity

INTERVAL BETWEEN ONSET AND DEATH: 33 hr. 25m

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(B) DUE TO:
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY occur?

22. I certify that (I) (this hospital) attended the deceased from 9:37 pm 5/13 19 65 to 6:12 pm 5/14 19 65, that (I) (we) last saw the deceased alive on 5/14/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: W. Stanley Ford M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED: 5/15/65

23C. PHYSICIAN'S NAME (Type) M.D. 23D. ADDRESS: Mercy Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/18/65	NATIONAL	BALTO.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 1-9 1965	Robert E. Farley M.D.	Paul E. Chenowith	3611 Chesterfield Ave

VS 150-REV. 1/1/65

P-624 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5312 Registered No. 65 5312

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARGARET PIRKLE

2. DATE AND HOUR OF DEATH: 5/13/65 | 2:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceosed lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: BALTIMORE Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00
D. STREET ADDRESS (If rural, give location): 1672 MUSSULA ROAD

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In yeors last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	WHITE	MARRIED	12-7-16	48		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	—	GEORGIA	USA

13. FATHER'S NAME: WILLIAM ANDREWS

14. MOTHER'S MAIDEN NAME: MARY BIGGAR

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give wor or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	—	UNKNOWN	MR. WELDON PIRKLE	SAME

MEDICAL CERTIFICATION

18. 430.01

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complicotion which coused deoth.)

CAUSE OF DEATH

(A) ~~DUE TO~~ Acute bacterial endocarditis with vegetation of aortic valves and embolism, renal infarcts. — INTERVAL BETWEEN ONSET AND DEATH

(B) ~~DUE TO~~ Pulmonary edema, severe, — INTERVAL BETWEEN ONSET AND DEATH

(C) Rheumatic cirrhosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		YES	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-29 19 65 to 5-13 19 65, that (I) (we) last saw the deceased alive on 5-13 19 65 and thot In(my) (our) opinion deoth accurred an the date and haur and fram the couses stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
Frederick B. Smith MD					MAY 13, 1965

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
FREDERICK B. SMITH		UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	MAY 15, 1965	TRINITY EPISCOPAL	MANOR ROAD GLENARM MD

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	Robert E. Faulkner	WM. COOK BROOKS	1050 YORK ROAD TOWSON, MD 21204

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

8 9

F-5001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5313 Registered No. 65 5313

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): DANIEL R. FINN

2. DATE AND HOUR OF DEATH: MAY 11, 1965 8:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTO. 29, MD.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): TOWSON 5300
D. STREET ADDRESS (If rurol, give locotion): 110 BURKE AVENUE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In yeors lost birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	WHITE	MARRIED	2-21-99	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED	BALTO. GAS & ELEC.	MARYLAND, BALTIMORE	U.S.A.

13. FATHER'S NAME: ALEXANDER FINN

14. MOTHER'S MAIDEN NAME: JULIA C. KELLY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	-----		ST. AGNES HOSPITAL, WILKENS & CATON AVE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) DUE TO: Bil. Bronchopneumonia
(B) DUE TO: Coma Toxemia
(C) Chr. Adrenalitis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Exfoliative dermatitis

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Boltimore City, give exact locotion)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Yeor) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify thot (I) (this hospitol) ottended the deceosed from MAY 11 19 65 to MAY 11 19 65, that (I) (we) lost sow the deceased alive on MAY 11 19 65 ond thot in (my) (our) opinion deoth occurred on the date ond hour ond from the causes stoted obove. (I) (We) (did) (did not) view the body after deoth.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐ 23B. DATE SIGNED: 5-12-65

23C. PHYSICIAN'S NAME (Type): [signature] M.D. 23D. ADDRESS: ST. AGNES HOSPITAL, WILKENS & CATON AVE.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	May 14, 1965	ST. FRANCIS CEMETERY	ABINGDON MARYLAND

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	Robert E. Faber, M.D.	WM. COOK BROOKS TOWSON	1050 YORK RD TOWSON, MD 21204

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-615 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 5314 M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5314

1. NAME OF DECEASED (Type or Print): Anthony M. Erpenstein

2. DATE AND HOUR OF DEATH: 5-14-65 | 9:30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): 4019 Echodale Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 27-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4019 Echodale Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Widowed	Dec. 8, 1877	87		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Maintainence Man	Sealtest Bakery	Balto. Md.	U.S.A.

13. FATHER'S NAME: Anthony A. Erpenstein

14. MOTHER'S MAIDEN NAME: Babbara Elizabeth Wendell

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	218-09-3464	Lillian Erpenstein	Same

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. 420.0 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart foilure, asthenio, etc. It means the diseose, injury or camplicotion which caused death.)	(A) Arteriosclerotic Heart Disease	13 yrs.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if ony, giving rise to the obove cause (A) stoting the UNDERLYING CONDITION last.	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Feb 2 1952 to May 14 1965, that (I) (~~we~~) (~~last~~) saw the deceased alive on MAY 14 1965 and that in (~~my~~) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☑	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
Albert J. Himelfarb					5/17/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Albert J. Himelfarb M.D.	3501 St. Paul St. Balto 18 Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-18-65	Baltimore Cemetery	Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	Robert E. Farley M.D.	John C. Miller Inc.	6415 Belair Rd.

VS 150-REV. 1/1/65

L-520 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5315 Registered No. 65 5315

1. NAME OF DECEASED (Type or Print): John Long
2. DATE AND HOUR OF DEATH: May 17, 1965 M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gould Convalescent Home
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) — A. STATE: Maryland B. COUNTY: Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-10
D. STREET ADDRESS (If rural, give location): 8317½ Philadelphia Road

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Widowed	Feb. 2, 1885	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Produce	Self employed	Baltimore Md.	U.S.A.

13. FATHER'S NAME: Charles Long
14. MOTHER'S MAIDEN NAME: Catherine Fritsch
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 218-32-3520
17. INFORMANT: Ashby Wychgram ADDRESS: 8317½ Philadelphia Rd.

MEDICAL CERTIFICATION

18. 33-0X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: Bronchopneumonia — 2 weeks

(B) DUE TO: Parkinson's disease — years

(C): arteriosclerosis — "

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED — While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 1965 to May 1965, that (I) (we) last saw the deceased alive on 5-10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John Long M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐ 23B. DATE SIGNED: 5-17-65
23C. PHYSICIAN'S NAME (Type): WYMAN K. HOYD M.D. 23D. ADDRESS: 6801 Belair Rd 6 Md

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	5-17-65	Greenmount Crematorium	Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	Robert E. Faylor M.D.	John C. Miller Jr.	6415 Belair Rd.

VS 150-REV. 1/1/65

6

M-600 1

65 5316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5316

BIRTH NO.

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): ANGELO MAURO

2. DATE AND HOUR OF DEATH: 5/18/65 — 1:15 AM. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL 33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: 202
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1744 E. LOMBARD ST.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
MALE	WHITE	NEVER MARRIED	10-26-90	74				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
TAVERN KEEPER	RETIRED	ITALY FROSINDYA	USA

13. FATHER'S NAME: DOMINIC MAURO

14. MOTHER'S MAIDEN NAME: ANGLEA DI POPE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 217-32-7866

17. INFORMANT: ETHEL MARCONI — ADDRESS: 7904 OAKLEIGH RD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO: 420.1

(B) DUE TO: Pulmonary Edema

(C): Myocardial Infarction

INTERVAL BETWEEN ONSET AND DEATH: 2 hours

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED — While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/18 1965 to 5/18 1965, that (I) (we) last saw the deceased alive on 5/18 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
John F Bigger Jr MD	M.D.	☐	☐	☑	5-18-65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
JOHN F. BIGGER JR. M.D.	M.D.	JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/20/65	MATHEWS CEMETERY	ODONNELL ST BALTO MD

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	Robert E. Farber M.D.	Doppel Bros	1800 E LOMBARD ST.

VS 1.50-REV. 1/1/65

B-162 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5317 Registered No. 65 5317

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Gray A. Beavers
2. DATE AND HOUR OF DEATH: 5-16-65 | 7:00 P M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND
   FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4/ Union Memorial Hospital
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
   A. STATE: Maryland B. COUNTY: 13-03
   C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
   D. STREET ADDRESS (If rural, give location): 3646 Keswick Road
5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M
8. DATE OF BIRTH: 2/24/94
9. AGE (In years last birthday): 71 — If Under 1 Yr. Months / Days; If Under 24 Hrs. Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired —
10B. KIND OF BUSINESS OR INDUSTRY: General Motors
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Homer Beavers
14. MOTHER'S MAIDEN NAME: Kate Cooper
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) —
    (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT: Mrs Ruth Stiles (Niece) ADDRESS: 1107 Weldon Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) DUE TO: Left middle Cerebral A. Thrombosis — 5-1-65

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(B) DUE TO: Arteriosclerotic cardiovascular disease
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Severe Pulmonary Emphysema

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPRDX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED — While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5—3— 19 65 to 5—16— 19 65, that (I) (we) last saw the deceased alive on 5-16— 19 65 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Miriam R. Cohen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 5/16-65
23C. PHYSICIAN'S NAME (Type): DR MIRIAM R COHEN
23D. ADDRESS: Union Memorial Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 5/20/65
24C. NAME of CEMETERY or CREMATORY: Woodlawn
24D. LOCATION (City, town, or county) (State): Woodlawn, Md

25A. DATE REC'D BY HEALTH DEPT.: MAY 19 1965
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Austin E. Donovan ADDRESS: 3818 Roland Ave

VS 150-REV. 1/1/65

G-650 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5318 Registered No. 65 5318

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) GRIM JENNIE

2. DATE AND HOUR OF DEATH MAY 15, 1965 2·20 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion) SINAI HOSPITAL OF BALTIMORE.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY 15-11
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 3520 HILTON RD.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	WHITE	MARRIED	1/7/74	91		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE	—	BALTO. MD	USA

13. FATHER'S NAME RICHARD MARTIN

14. MOTHER'S MAIDEN NAME MARGARET ROBINSON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. —

17. INFORMANT ADDRESS MRS. JOHN POWELL - 3370 HICKORY AVE

MEDICAL CERTIFICATION

18. 420.1 - E 904.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) MYOCARDIAL INFARCTION

DUE TO ATHEROSCLEROTIC CARDIO VASCULAR DISEASE.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. FRACTURE RIGHT HIP INTERTROCHANTERIC.

CERTIFICATION APPROVED BY A MED. EXAMINER M.E.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
MAY 12, 1965	FRACTURE RIGHT HIP	No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Nursing Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Ashburton Nursing Home

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 5 1965 ?

21E. INJURT OCCURRED While At Work ☐ Not While At Work ☒

21F. HOW DID INJURT OCCUR? Opportunity Fell

22. I certify that (I) (this hospital) attended the deceased from MAY 11, 1965 to MAY 15, 1965, that (I) (we) last saw the deceased alive on MAY 15, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Banchob Bhumithavorn M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED MAY 15, 1965

23C. PHTSICIAN'S NAME (Type) BANCHOB BHUMITHAVORN M.D.

23D. ADDRESS C/O SINAI HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME of CEMETERT or CREMATORT	24D. LOCATION (City, town, or county) (State)
Burial	5/19/65	Stewartstown, Pa	Pennsylvania.

25A. DATE REC'D BY HEALTH DEPT. MAY 19 1965

25B. NAME OF REGISTRAR Robert E. Falkenhan

25C. FUNERAL DIRECTOR Austin E. Konovan ADDRESS 3818 Plainfield

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-258 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5319 Registered No. 65 5319

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Cashen, Miss Johanna

2. DATE AND HOUR OF DEATH: MAY 15-65 | 5.35 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 206 S. Monastery Ave #29

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W		MARCH 26, 1887	78				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housemother	HOSPITAL	Ireland	

13. FATHER'S NAME: Thomas Cashen

14. MOTHER'S MAIDEN NAME: Mary Maher

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	220-30-2900	Mrs Margaret M Morley	2065 Monastery Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: CANCER of the STOMACH — INTERVAL BETWEEN ONSET AND DEATH: MONTHS

(B) DUE TO:

(C):

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from MAY 15 - 1965 to MAY 15 - 1965, that (I) (we) last saw the deceased alive on MAY 15 - 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Agustin del Campo. M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: MAY 15-1965

23C. PHYSICIAN'S NAME (Type): AGUSTIN DEL CAMPO M.D.

23D. ADDRESS: Bon Secours Hosp. Balto, Md

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-18-65	Cathedral Cemetery	Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	Robert E. Farley M.D.	Farley Funeral Home	Catonsville, Md

VS 150-REV. 1/1/65

31-59-81 1
FR
6650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5320
M.E. CASE NO.
Registered No. 65 5320

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Marion Green

2. DATE AND HOUR OF DEATH: May 14, 1965 | 4:10 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 26-12
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4940 Eastern Avenue 21224

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Married (?)	6-10-1919	45				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE	NONE	Maryland	U. S. A.

13. FATHER'S NAME: probably LEIDLICH

14. MOTHER'S MAIDEN NAME: ?????? NOT KNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
?=probably none	prob. none	RECORDS: BCH	4940 Eastern Avenue 21224

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Diffuse Degenerative Central Nervous System Disease — INTERVAL BETWEEN ONSET AND DEATH: 7 Years

DUE TO

(B) DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Possible Pneumonia

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 25, 1961 to May 14, 1965, that (I) (we) last saw the deceased alive on May 14, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J. B. Zachary, M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ — 23B. DATE SIGNED: May 14, 1965

23C. PHYSICIAN'S NAME (Type): Dr. James B. Zachary M.D.

23D. ADDRESS: 4940 Eastern Avenue 21224

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/19/65	Loudon Park Cemetery	Baltimoe, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 19 1965	Robt E. Fahey M.D.	Stewart & Mowen Co. 108 W.North Av., City

VS 150-REV. 1/1/65

1040 KRIEGER, MARK K-626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5321 Registered No. 65 5321

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARK KRIEGER.

2. DATE AND HOUR OF DEATH: 5/14/65 | 4:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balt.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00
D. STREET ADDRESS (If rural, give location): 6303 Blenheim Rd

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED/ DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M/F M	White	Married	3/18/ or	63				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired		Balto Md	US

13. FATHER'S NAME: William A. Krieger

14. MOTHER'S MAIDEN NAME: Mary Balster

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Wife	Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO	Sepsis	3 days
(B) DUE TO	U.T. inf.	
(C)	Parkinsonism	5 years

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		YES	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
NO	NO	

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/13/ 1965 to 5/14/ 1965, that (I) (we) last saw the deceased alive on 5/14/ 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
Robert Hecht					5/14

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Robert Hecht		Balt. City Hosp.

24A. BURIAL CREMATION REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	May 1965	Lorraine Cem	Balto Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	Robert E. Foley, M.D.	Odenheimer	6067 Hayward

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

t-512 1

BIRTH NO. 65-11697 65 5322

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 5322 4

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Baby Boy Thompson

2. DATE AND HOUR OF DEATH: 5/16/65 | 11:55 PM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): Lutheran Hospital of Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: 25-33
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2203 CEDLEY St #30

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	Single	5/16/65					45

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	—	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thompson Edward V.	Linder Thompson Wall

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		Family	Same

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
1B. 7767 I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) DUE TO: Immaturity	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(B) DUE TO:	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/16 1965 to 5/16 1965, that (I) (we) last saw the deceased alive on 5/16 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
H. Golpira					5/16/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
HOSSEIN GOLPIRA M.D.	

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-18-65	Holy Cross Cem	Balto 25 Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	Robert E. Farley M.D.	McCully Funeral Hm	2370 Pitcher

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-160 1

BIRTH NO. 65 5323

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 5323

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): ODELL S. HAFFER

2. DATE AND HOUR OF DEATH: 5/17/65 — 9:20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddiess or locotion): SAINT AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 25-43
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1722 SPENCE STREET

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
MALE	WHITE	WIDOWED	7/27/03	61				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED DRAFTSMAN	B & O RR	MARYLAND	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
ADAM W. HAFFER	LATIMER DIFFENDAL

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO			RICHARD O. HAFFER	1722 SPENCE ST. 21230

MEDICAL CERTIFICATION

18. 4221 I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO

(B) Arteriosclerotic CVD

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from Dec. 1954 to May 17 1965, that (I) (we) last saw the deceased alive on May 7 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
Herbert J. Levickas		☒	☐	☐	5/18/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
HERBERT J. LEVICKAS		1073 Maiden Choice Lane (29)

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/21/65	LOUDON PARK CEMETERY	BALTIMORE, MD.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	Robert E. Fahrney	HOWARD H. HUBBARD	4107 WILKENS AVE. 21229

VS 150-REV. 1/1/65

L-500 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5324 Registered No. 65 5324

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Marie A. Layne

2. DATE AND HOUR OF DEATH: May 16, 1965 | 8 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): 702 Bethnal Rd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 25-31
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rurol, give locotion): 702 Bethnal Rd.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In yeors lost birthdoy)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Divorced	Sept. 12, 1901	63				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework	Own Home	Maryland	U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Raymond T. Cavanaugh	702 Bethnal Rd

MEDICAL CERTIFICATION

CERTIFICATION APPROVED BY (CHIEF OR ASST. MEDICAL EXAMINER): H. H. Baylus M.D.

CAUSE OF DEATH

1B. 181.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not meon the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complicotion which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the obove cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO	Carcinoma, bladder	3 years
(B) DUE TO		
(C)		

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or obout home, form, foctory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact locotion)

21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify thot (I) (this hospitol) attended the deceased from March 1964 to January 1965, thot (I) (we) last saw the deceased olive on January 1965 and that in (my) (our) opinion death occurred on the dote ond hour and from the causes stoted obove. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
H H Baylus M.D.	Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐	17 May 65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
H. H. BAYLUS M.D.	1600 WILKENS AVE BALTO, 23, MD.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/19/65	Loudon Park Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	Robert E. Lauer	Walters Funeral Home Pa H. Stricker	

VS 150-REV. 1/1/65

1

K-400

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 5325

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5325

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Bessie Kelly

2. DATE AND HOUR PRONOUNCED DEAD: May 16, 1965 | 9:05 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Franklin Square Hospital

36

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-02
D. STREET ADDRESS (If rural, give location): 1500 W. Baltimore Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months / Days / Hours / Min.
Female	White	Divorced	Nov. 22, 1923	41	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		West Virginia	U.S.A.

13. FATHER'S NAME: Henry DeHart

14. MOTHER'S MAIDEN NAME: Emily Anderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Russell F. Kelly	1721 N. Calvert St.

MEDICAL CERTIFICATION

18. 581.0 Y 002.1

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) DUE TO: Fatty metamorphosis of liver

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO:
(C):

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Advanced active pulmonary tuberculosis

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		yes	yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ Partial and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: John E. Adams M.D.
EXAMINER'S NAME (Type): John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: May 16, 1965

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/19/65	St. Paul's Fifth Reformed	Cardiff Ave. Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	Robert E. Farley M.D.	Wm. Cook-Brooks Inc.	1217 St. Paul St.

VS 151-REV. 1/1/65

LS: 43-04-25 1

S-166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5326 Registered No. 65 5326

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): James Sevrer (Sevier)

2. DATE AND HOUR OF DEATH: May 16, 1965 | 11:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hosptials 4940 Eastern Avenue Baltimore, Maryland #21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 5-01

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 5 N. Exeter Street #21202

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Single	8-5-1884	80				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		South Carolina	U. S. A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		RECORDS: BCH:	4940 Eastern Avenue #21224

MEDICAL CERTIFICATION

18. #430.01

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Arteriosclerosis

DUE TO

(B) Acute Brain Syndrome

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 9, 19 65 to May 16, 19 65, that (I) (we) last saw the deceased alive on May 16, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: C. J. Carpenter M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. XX

23B. DATE SIGNED: May 16, 1965

23C. PHYSICIAN'S NAME (Type): Dr. Charles Carpenter M.D.

23D. ADDRESS: 4940 Eastern Avenue Baltimore, Maryland #24

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	5/17/65	Gowansville Cemetery	Landrum South Carolina

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	Robert E. Farley, M.D.	Wm. Cook-Brooks, Inc.	1217 St. Paul St. Baltimore Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-5601

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5327 — Registered No. 65 5327

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mary C. Bohn

2. DATE AND HOUR OF DEATH: May 17, 1965 | 2:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 308 Regester Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore (12)
D. STREET ADDRESS (If rural, give location): 308 Regester Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Never Married	Aug. 29, 1876	88		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Baltimore, Maryland	U.S.A.

13. FATHER'S NAME: William Bohn

14. MOTHER'S MAIDEN NAME: Teresa Schwing

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	Mrs. Margaret Middlekauff	308 Regester Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardio-vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

DUE TO

(B) Cerebral ~~Hemorrage~~ Hemorrhage — 1 wk.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from June 15, 19 63 to May 17, 19 65, that (I) (~~we~~) last saw the deceased alive on May 14, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
Philip D. Flynn M.D.	Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐	5-17-65

23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS
Philip D. Flynn, M.D.	M.D.	11 E. Chase Street

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	May 19, 1965	Holy Redeemer Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 19 1965	Robert E. Farley M.D.	Wm. Cook-Brooks, Inc.	1217 St. Paul St.

VS 150-REV. 1/1/65

F-5328 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5328
M.E. CASE NO.
Registered No. 65 5328

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): William F. Gams

2. DATE AND HOUR OF DEATH: May 16, 1965 | 7:45 a M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location): Park Hill Convalescent Home, 1802 Eutaw Place, Baltimore, Maryland 21217

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 14-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21217
D. STREET ADDRESS (If rurol, give location): 1802 Eutaw Place

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
male	white	widowed	Dec. 31, 1883	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret'd Buyer		Baltimore, Maryland	U.S.A.

13. FATHER'S NAME: Herman Gams

14. MOTHER'S MAIDEN NAME: Bertha Scherf

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	212-01-3124	Howard VanCourt, 7402 Wynewood Rd., Baltimore	21207

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
I	(A) DUE TO: Ant. Sol. Heart disease	several days
	(B) DUE TO: Gen. Art. Scl.	chronic
	(C)	
II	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Parkinsonism - senile, Prostatism, Emphysema	chronic

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from 2/11 19 59 to 5/16 19 65, that (I) (we) last saw the deceased alive on 5/15 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Louis V. Blum, M.D. M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 5/17/65

23C. PHYSICIAN'S NAME (Type): Louis V. Blum, M.D. M.D.

23D. ADDRESS: 3502 West Rogers Avenue, Baltimore

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5-18-65	Baltimore Cemetery	Baltimore

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 19 1965	Robert E. Foland	Wm. Cook-Brooks, Inc., 1217 St. Paul Street

VS 150-REV. 1/1/65

H-670

1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5329 Registered No. 65 5329

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Harris, David

2. DATE AND HOUR OF DEATH: 5/18/65 7:45 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Montebello State Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 13-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 604 Reservoir St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	Negro	Married	6/17/1908	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Labourer		North Carolina	U.S.A

13. FATHER'S NAME: Sam Brown

14. MOTHER'S MAIDEN NAME: Lucy

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		212-05-5227	Hospital Records.	

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I 1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not meon the mode of dying, e.g., heart foilure, osthenio, etc. It means the disease, injury or camplicatian which caused deoth.)	(A) Adenocarkenoma of Stomach	1 Year
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if ony, giving rise to the above couse (A) stoting the UNDERLYING CONDITION last.	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
8/13/64	Exploratory Lap.	no	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/7/64 19 to 5/18/65 19, that (I) (we) last saw the deceased alive on 5/18/65 19 and that in(my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☑	23B. DATE SIGNED
Daniel G. Lai					5/18/65

23C. PHYSICIAN'S NAME (Type) Daniel G. Lai M.D.

23D. ADDRESS Montebello Hospital MD Baltimore 16,

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/24/65	Mt Auburn	Baltimore, Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 20 1965	Robert E. Farley, M.D.	Charles A. Rice	661 W. Barre St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-620

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5330 Registered No. 65 5330

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GRIGGS, MARY Virginia

2. DATE AND HOUR OF DEATH: 5/18/65 1.20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): 46 LuTheran Hospital of Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland. B. COUNTY: 15-48
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore.
D. STREET ADDRESS (If rural, give location): 2205 Allendale Rd.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	Color	W	10-1880	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
DOMESTIC		Virginia	U.S.A

13. FATHER'S NAME: James Jones

14. MOTHER'S MAIDEN NAME: Amanda

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Emma L. BrigRT.	same.

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. 422.1 I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Cardio Vascular and Pneumonia.	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(B) DUE TO	
	(C)	
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/1/65 / 1965 to 5/18 1965, that (I) (we) last saw the deceased alive on 5/18 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (~~have~~) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
S. Rojaee					5/18/65.

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
SoRoosh. Rojaee		LuTheran Hosp. of Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/22/65	Mt Auburn	Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 20 1965	Robert E. Tankey M.D.	Charles A. Rice 661 W. Barre St

VS 1S0-REV. 1/1/65

1

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 5331

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5331

M.E. CASE NO.

J-525

1. NAME OF DECEASED (Type or Print): ISAAC E. JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD: May 19, 1965 | 11:30 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION: (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 1011 N. Carey St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-01
D. STREET ADDRESS (If rural, give location): 1011 N. Carey St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
male	colored	married	December 23/1894	70				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
longshoreman		Md	

13. FATHER'S NAME: Elijah Johnson

14. MOTHER'S MAIDEN NAME: Minnie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mamie Johnson	same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

4221

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 5-19-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county)	(State)
Burial	5-22-65	New Cathedral Cem	Balto	Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 20 1965	Robert E. Faber M.D.	Joseph J. Sullivan	1011 Hollins

VS 151-REV. 1/1/65

S-530 1

RELEASED BY MEDICAL EXAMINER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 5332 M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5332

1. NAME OF DECEASED (Type or Print): Smith, James E.

2. DATE AND HOUR OF DEATH: May 19, 1965 | 1:05 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): St. Joseph Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 8-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21213
D. STREET ADDRESS (If rural, give location): 1431 Kenhill Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	Negro	Widowed	2-18-1893	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Bethlehem Steel Corp.	Virginia	

13. FATHER'S NAME: Alfred Smith

14. MOTHER'S MAIDEN NAME: Martha Ball

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	217-16-5547		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
I: Massive pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

465 + E 900.0

CHIEF MEDICAL EXAMINER'S CASE NOT A MEDICAL EXAMINER'S CASE — Charles S. Wehr M.D. CHIEF OR ASST. MEDICAL EXAMINER 5/20/65

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
April 27, 1965	Fracture, lt. humerus	No	No

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
☐	Home	1431 Kenhill Ave., Baltimore, Md.

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☒	21F. HOW DID INJURY OCCUR?
March 31, 1965		Patient fell down steps

22. I certify that (I) (this hospital) attended the deceased from March 31, 1965 to May 19, 1965, that (I) (we) last saw the deceased alive on May 19, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Eduardo C. Yatco M.D. | Attending Phys. ☐ | Med. Director ☐ | Staff Phys. ☑ | 23B. DATE SIGNED: May 19, 1965

23C. PHYSICIAN'S NAME (Type): Eduardo C. Yatco M.D. | 23D. ADDRESS: 1400 N. Caroline St., Baltimore, Maryland 21213

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	May 22 1965	Mt Calvary Cem.	Brooklyn Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR, ADDRESS
MAY 20 1965	Robert E. Parker M.D.	Earl Gilmore - 1827 W. North Ave

VS 150-REV. 1/1/65 N 512.0

1

S-550

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 5333 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No. 65 5333

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) MARY T. SHANAHAN	2. DATE AND HOUR PRONOUNCED DEAD 5-17-65 | 8:40 A. M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 4641 MARBLE HALL ROAD	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: 11-01 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore D. STREET ADDRESS (If rural, give location): 1114 Guilford Avenue 21202

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months / Days / Hours / Min.
Female	White	Divorced	Aug. 26, 1906	58	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	U. S. Gov't	Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Benford C. Stonnell	Leola Haynes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None		Mr. William B. Stonnell	4641 Marble Hall Road Baltimore, Md. 12

MEDICAL CERTIFICATION

E 970.2

18. **CAUSE OF DEATH**

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Barbiturate poisoning
DUE TO
(B)
DUE TO
(C)

ANTECENDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Home	4641 Marble Hall Road

21D. TIME OF INJURY (APPROX.) (Month)	(Day)	(Year)	(Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
5	17	'65	? m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Ingested overdose of barbiturate

22. I certify that I held on Inquiry [ ] Inspection [X] Autopsy [ ] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [X] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE R B Fisher M.D.
EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER [X]
ASSISTANT MEDICAL EXAMINER [ ]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED 5-17-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/20/1965	Druid Ridge Cemetery	Pikesville, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 20 1965	Robert E. Fahey	Wm. J. Tilton & Sons	Balto., Md. 21217 North Pa. Ave.

VS 151-REV. 1/1/65

N 971.0

S-4327 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5334 — Registered No. 65 5334

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): George C. Schildwachter
2. DATE AND HOUR OF DEATH: May 18, 1965 | 6:00 P.M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5101 Belleville Avenue, Baltimore, Maryland 21207
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) — A. STATE: Maryland — B. COUNTY: 28-02 — C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore — D. STREET ADDRESS (If rural, give location): 5101 Belleville Avenue 21207
5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: Dec. 19, 1891
9. AGE (In years last birthday): 73 — If Under 1 Yr. Months / Days; If Under 24 Hrs. Hours / Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk - Retired
10B. KIND OF BUSINESS OR INDUSTRY: B and O
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?: United States
13. FATHER'S NAME: Herman Schildwachter
14. MOTHER'S MAIDEN NAME: Henrietta Klinger
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): Yes — World War I
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Virginia V. Schildwachter — ADDRESS: 5101 Belleville Ave Balto., Md. 7

CAUSE OF DEATH

18. 4-20-1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Coronary Occlusion	1 day
DUE TO		
(B)	Arteriosclerotic cardiovascular disease	3 years
DUE TO		
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION: 0 ********
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: *******
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: **********
21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (*********examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): ********
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): **********
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): ********
21E. INJURY OCCURRED: ******* While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?: **********

22. I certify that (I) ~~(this physician)~~ attended the deceased from ____ 19 55 to May 19 65, that (I) (XX) last saw the deceased alive on May 17, 19 65 and that to (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (XX) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Millard T. Traband, Jr. M.D. — Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 19 May 1965
23C. PHYSICIAN'S NAME (Type): Millard T. Traband, Jr. M.D.
23D. ADDRESS: 5101 Gwynn Oak Ave. Baltimore, Md. 21207

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 5/21/1965
24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: MAY 20 1965 — Robert E. Foskey
25B. NAME OF REGISTRAR:
25C. FUNERAL DIRECTOR: Wm. J. Tibbon & Son — ADDRESS: Baltimore, Md. 21217 North Ave.

VS 150-REV. 1/1/65

0-450 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

BIRTH NO. 65 5335 Registered No. 65 5335

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Elza M. Olin

2. DATE AND HOUR OF DEATH: May 18, 1965 - 7:45 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND (If not in hospital or institution, give address or location)
CERTIFICATE CORRECTED 6-7-65
HOSPITAL OR INSTITUTION: 5903 Greenhill Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: District of Columbia
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Washington
D. STREET ADDRESS (If rural, give location): 3636 16th Street N. W.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
female	white	divorced	Dec. 27, 1896	68				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired	science service	Latvia	U.S.A.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	no	108-26-4202	Miss Mary Balodis	5903 Greenhill Ave. Balto.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ADENOCARCINOMA OF OVARIES — INTERVAL BETWEEN ONSET AND DEATH: 24 months

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this ~~hospital~~) attended the deceased from May 4 1965 to May 18 1965, that (I) (~~was~~) last saw the deceased alive on May 12 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Adam S Swiss M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: May 18, 1965

23C. PHYSICIAN'S NAME (Type): ADAM C. SWISS M.D.

23D. ADDRESS: 6432 Belair Road, Balto. 6, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	May 22, 1965 ~~May 20, 65~~	Rock Creek Cemetery	Washington, D.C.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 20 1965	Robert E. Farley, M.D.	S. H. Hines Funeral Home	

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

AO 153 6-7-65 XIIA.

R-200 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5336 Registered No. 65 5336

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): DOROTHY HAZEL ROSS

2. DATE AND HOUR OF DEATH: May 19, 1965 9: 40 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
US Public Health Service Hospital
Wyman Pk. Drive & 31st Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Essex
D. STREET ADDRESS (If rural, give location): 43 Clipper Road 21221

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	White	Married	4/13/22	43		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Mass.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Wm. G. Thompson	Mildred N. Perkins

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	026-12-5290	Records- US PHS Hospital	Balto, Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. 1547 I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Lobular pneumonitis	Days
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(B) DUE TO Adenocarcinoma of rectum with metastases	4 yrs.
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Suppurative pyelonephritis	Unknown

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		yes	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 11 19 65 to May 19 19 65, that (I) (we) last saw the deceased alive on May 19 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
Aaron Lupovitch					5/19/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Aaron Lupovitch, Surgeon (R)		US PHS Hospital, Balto, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/21/1965	Baltimore National Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 20 1965	Robert E. Farley, M.D.	Wm. J. Tichnor & Son	Balto., Md. 21217 North & Pa. aves.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

VS 150-REV. 1/1/65

40-48-81 AM 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO. 65 5337

Registered No. 65 5337

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): James Hussey

2. DATE AND HOUR OF DEATH: 5-15-65 | 10:15 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 7-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 711 North Milton Avenue #21213

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Separated	5-27-92	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	U. S. A.

13. FATHER'S NAME: Alonzo R. Hussey

14. MOTHER'S MAIDEN NAME: Annie Hagen

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	213-03-6038	RECORDS: B.C.H.	4940 Eastern Avenue #21224

MEDICAL CERTIFICATION

18. 493X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gram Negative Sepsis — INTERVAL BETWEEN ONSET AND DEATH: 2 Days

DUE TO

(B) Pneumonia — 2 Days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C) Chronic Lung Disease — ?

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from 5-23- 19 64 to 5-15 19 65, that (I) (we) last saw the deceased alive on 5-15 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
J. B. Zachary		☐	☐	☒	5-15-65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Dr. J. B. Zachary		4940 Eastern Avenue #21224

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	5/20/65	Loudon Park Crematory	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 20 1965	R. Bart E. Fahey M.D.	Wm. J. Tichnor & Sons	Balto, Md. 21217 North Pa ave.

VS 150-REV. 1/1/65

W-2427 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5338 Registered No. 65 5338

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): George Henry Wessels

2. DATE AND HOUR OF DEATH: 5/17/65 8 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 13-19
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1022 Union Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	Divorced	8-9-82	82				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Dairy Farmer		Maryland	USA

13. FATHER'S NAME: Henry Wessels

14. MOTHER'S MAIDEN NAME: Katie Bats

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—	—	Robt-Turbaugh - nephew	Same

MEDICAL CERTIFICATION

18. 422.1 I — CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: ACUTE MYOCARDIAL INFARCT, ANTERIOR & POSTERIOR.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO: ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE.

(C) CONGESTIVE HEART FAILURE. R&P.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-13-1965 to 5-17-1965, that (I) (we) last saw the deceased alive on 5-17-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Miriam R. Cohen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 5-17-65

23C. PHYSICIAN'S NAME (Type): MIRIAM R. COHEN M.D.

23D. ADDRESS: Union Memorial Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/20/65	Pleasant Hill	Balto Co, Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 20 1965	Robt E. Talley, M.D.	Austin E. Bonacci	3818 Plainfield

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

C-216

65 5339

BALTIMORE CITY HEALTH DEPARTMENT

65 5339

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) E. ANITA CASPARRIELLO	2. DATE AND HOUR PRONOUNCED DEAD: May 18, 1965 | 11:39 p M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): St. Joseph Hospital	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-01; D. STREET ADDRESS (If rural, give location): 6000 Arizona Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days / Hours / Min.
female	white	widowed	2/19/1899	66	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	at home	Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edward Quillen	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	215-22-2407	Mary Rytel, dght. above	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I 7432

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease

DUE TO

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE R Breitenecker M.D.

EXAMINER'S NAME (Type) Rudiger Breitenecker

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 5-19-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/22/65	New Cathedral Cem.	Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 20 1965	Robert E. Farley, M.D.	Schimunek Funeral Home, Inc. 3331 Bfehms Lane

VS 151-REV. 1/1/65

BIRTH NO. 65 5340

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 5340

1. NAME OF DECEASED (Type or Print): J. FRANK ASTARITA

2. DATE AND HOUR OF DEATH: 5-19-65 | 1.00 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location): THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 6-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 141 NORTH DECKER AVENUE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
MALE	WHITE	WIDOWED	3-9-00	65				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Pa. R. R.	Baltimore, Md.	

13. FATHER'S NAME: Salvatore Astarita

14. MOTHER'S MAIDEN NAME: Terese Aversa

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Alexander J. Astarita, brother, above — ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
1B. 420.1 I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) DUE TO: Myocardial Infarction	2 hrs
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(B) DUE TO:	
	(C)	
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 12 M ~~AM~~ May 19, 1965 to 1 30 AM - May 19, 1965. that ~~I~~ (we) last saw the deceased alive on May 19, 1965 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~I~~ (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE				23B. DATE SIGNED
Kenneth E. Quickel M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. X	5/19/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
KENNETH E. QUICKEL M.D.	Johns Hopkins Hospital.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/22/65	Holy Redeemer Cem.	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 20 1965	Robert E. Farley, M.D.	Schimunek Funeral Home, Inc.	2601 E. Madison St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Released with permission of Medical Examiner

B-453 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5341 — Registered No. 65 5341

1. NAME OF DECEASED (Type or Print): JOHN FREDERICK BLUNT
2. DATE AND HOUR OF DEATH: 5-17-65 | 3:10 P M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) — A. STATE: Maryland — B. COUNTY: 103 — C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore — D. STREET ADDRESS (If rural, give location): 2419 Foster Avenue 21224
5. SEX: male
6. RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): single
8. DATE OF BIRTH: 9/7/1909
9. AGE (In years last birthday): 55 — If Under 1 Yr. Months / Days — If Under 24 Hrs. Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Upholster
10B. KIND OF BUSINESS OR INDUSTRY: Foster Brothers
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Alfred Blunt
14. MOTHER'S MAIDEN NAME: Bertha Bussey
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — ADDRESS: Irene Weinbeck 3726 Elmley Avenue #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(a) Cardiac Arrest (Ventricular Fibrillation) — MIN
DUE TO
(b) Acute Myocardial Infarction — HRS
DUE TO
(c) ASCVD — YRS

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Probable Digitalis Toxicity — UNKN

NOT MEDICAL EXAMINER CASE — M.D. — CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED — While At Work ☐ — Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 5-17 1965 to 5-17 1965, that ~~(I)~~ (we) last saw the deceased alive on 5-17 19 65 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) (~~didn't~~) view the body after death.

23A. SIGNATURE: William R Law — M.D. — Attending Phys. ☐ — Med. Director ☐ — Staff Phys. ☒ — 23B. DATE SIGNED: 5-17-65
23C. PHYSICIAN'S NAME (Type): WILLIAM R LAW — M.D. — 23D. ADDRESS: MERCY HOSPITAL BALTO MD

24A. BURIAL CREMATION, REMOVAL (Specify): Burial — 24B. DATE: 5/21/65 — 24C. NAME of CEMETERY or CREMATORY: Friendship Cemetery — 24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: MAY 20 1965 — 25B. NAME OF REGISTRAR: Robert E. Faber M.D. — 25C. FUNERAL DIRECTOR — ADDRESS: Schimunek Funeral Home, Inc. 3331 Brehms Lane #13

VS 150-REV. 1/1/65

1

K-240

BIRTH NO. 65 5342 MEDIC[redacted]RTIFICATE OF DEATH Registered No. 65 5342

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) JAM[redacted]

2. DATE AND HOUR PRONOUNCED DEAD: May 17, 1965 7:05 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): BALTIMORE CITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-02
D. STREET ADDRESS (If rural, give location): 2508 E. Madison

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Widowed	April 13, 1897	68				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Gardner (Ret.)	City Parks	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: John Kuzel

14. MOTHER'S MAIDEN NAME: Anna Pokorny

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-05-8630 A.

17. INFORMANT: William J. Kuzel ADDRESS: 7514 Marston Road #7

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Acute Asthylaxis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type): John E. Adams M.D.

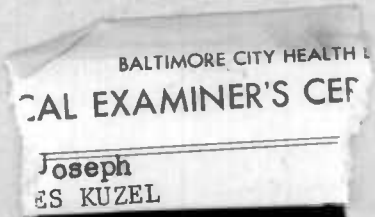
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 5-18-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/21/65	Mt. Carmel Cemetery	Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 20 1965	Robert E. Faulkner	Schimunek Funeral Home, Inc. 2601-03-05 E. Madison Street #5

VS 151-REV. 1/1/65


BALTIMORE CITY HEALTH
CAL EXAMINER'S CE
Joseph
ES KUZEL

SAB-43-04-58 1
L-558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5343 Registered No. 65 5343
M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Edward Lannon
2. DATE AND HOUR OF DEATH: 5-18-1965 10:00 AM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 4-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 102 North Paca Street, 21201

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Widowed	2-23-1896	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Office	Maryland	U.S.A.

13. FATHER'S NAME: Clarence Lannon
14. MOTHER'S MAIDEN NAME: Rose Bradley

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	218-10-4001	Records: BCH-4940 Eastern Avenue	21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(B) DUE TO	
	(C) Carcinoma of Colon	6 months
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-9- 1965 to 5-18- 1965, that (I) (we) last saw the deceased alive on 5-18- 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: C.C. Carpenter M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED: 5-18-1965

23C. PHYSICIAN'S NAME (Type): Dr. C.C.J. Carpenter M.D. 23D. ADDRESS: 4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/21/65	New Cathedral	Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 20 1965	Robert E. Faile, M.D.	C.F. Evans & Son	8802 Harford Rd

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-426 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5344 Registered No. 65 5344

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Christine Bayless

2. DATE AND HOUR OF DEATH: 5-16-65 | 1:00 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 2202
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #21230
D. STREET ADDRESS (If rural, give location): 211 W. Hill St.

43

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F.	Negro.		9-28-21	43.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Cleaning Co	Ohio	

13. FATHER'S NAME: Known

14. MOTHER'S MAIDEN NAME: Nellie Mays

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	If yes, give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		169-30-2072	Lenny Tuftile	211 W. Hill St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

434.1 I

(A) OUE TO: Congestive Heart failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO: Uremia

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES.	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (~~I~~) (this hospital) attended the deceased from 5-9 1965 to 5-16 1965; that (~~I~~) (we) last saw the deceased alive on 5-16 1965 and that in (~~my~~) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.O.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
Camilo C. Balacuit Jr		☐	☐	☑	5-17-65.

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Camilo C. Balacuit, M. D		South Baltimore General Hosp

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/22/65	Mt Auburn	Balto City

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 20 1965	Robert E. Farley M.D.	Isaiah L Brown & Son	108 W Montgomery St.

VS 150-REV. 1/1/65

K-625 1

K625

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 5345

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

Registered No. 65 5345

1. NAME OF DECEASED (Type or Print): Krosney, Amelia (KRASNA)

2. DATE AND HOUR OF DEATH: 5/13/65, 11.25 A.M. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give sheet address or location)
Saint Agnes Hospital
Caton & Wilkens Ave 21229

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balt
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): ~~300 N. Dyer Rd. #30~~ 3323 KESSLER CT. Zone 27

53-00

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	(If Under 24 Hrs. Hours	Min.
F	W	WIDOW	June ?	76				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE		AUSTRALIA	

13. FATHER'S NAME: JOSEPH KRUSHELNICKI

14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): — —

16. SOCIAL SECURITY NO.: 220-03-8155

17. INFORMANT: JOSEPHINE A. GAVIN ADDRESS: 3323 KESSLER CT. 21227

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) "(~~Probable Infarction~~")
DUE TO
(B) A Acute Myocardial infarction 2 hrs.
DUE TO
(C) Diabetes mellitus several yrs.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED — While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-13-65 to 5-13-65, that (I) (we) last saw the deceased alive on 5-13-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: F. D. D'Arcy M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED: 5/13/65

23C. PHYSICIAN'S NAME (Type): Francis D. D'Arcy M.D. 23D. ADDRESS: St. Agnes Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-17-65	Holy Cross	A.A. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: MAY 20 1965 25B. NAME OF REGISTRAR: Robert E. Farley, M.D. 25C. FUNERAL DIRECTOR ADDRESS: Wm. S. Fialkowski 2007 Eastern Ave.

VS 150-REV. 1/1/65

D-255 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5346 Registered No. 65 5346

1. NAME OF DECEASED (Type or Print): MRS. MARGARET M. DEGNAN

2. DATE AND HOUR OF DEATH: MAY 17, 1965 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 3631 YOLANDO ROAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 9-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 3631 YOLANDO ROAD

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
FEMALE	WHITE	WIDOWED	MAY 21, 1887	77				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
AT HOME		BALTIMORE, MD.	

13. FATHER'S NAME: JOHN MC MAHON

14. MOTHER'S MAIDEN NAME: ELLEN HOGAN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			MISS ELIZABETH A. DEGNAN	3631 YOLANDO RD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
I (A)	Acute heart failure	
(B) DUE TO	Arteriosclerotic degenerative C.V. Disease	
(C) DUE TO	Auricular fibrillation	weeks
II	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4 May 1965 to 17 May 1965, that (I) (we) last saw the deceased alive on 17 May 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Joseph E. Muse Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐ 23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type): JOSEPH E. MUSE, JR. M.D. 23D. ADDRESS: 2725 N. Charles St (18)

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/20/65	NEW CATHEDRAL	BALTIMORE, MD.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 20 1965	Robert E. Farley, M.D.	H. W. MEARS & SON	805 N. CALVERT ST

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-530 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5347 Registered No. 65 5347

1. NAME OF DECEASED (Type or Print): ROSE SMITH
2. DATE AND HOUR OF DEATH: 5-16-65 | 7.30 P M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location): CHURCH HOME & HOSPITAL
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: md. B. COUNTY: Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53 00
D. STREET ADDRESS (If rurol, give location): 107 HOMBERG AVE.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F.	W.	married	9-26-92	72	8			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE		WISCONSIN	U.S.A.

13. FATHER'S NAME: FRED JORDAN
14. MOTHER'S MAIDEN NAME: LENA KNABE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Martin Smith	(Same)

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 170X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: CARCINOMA of THE — INTERVAL BETWEEN ONSET AND DEATH

(B) DUE TO: BREAST — months

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-3 19 65 to 5-16 19 65, that (I) (we) last saw the deceased alive on 5-16 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☑	23B. DATE SIGNED
Ephraim Barzaga					5-16-65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
EPHRAIM B. BARZAGA		CHURCH HOME & HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	5/19/65	Belair Mem Cem.	Belair	Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 20 1965	Robert E. Farley M.D.	Joseph Connelly Sons	300 more Ave. 21

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RELEASED AS NOT MEDICAL EXAMINER'S CASE. BY DR. FISHER, M E

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-508 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5348 Registered No. 65 5348

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ESTELLE PINE

2. DATE AND HOUR OF DEATH: 5-16-65 | 945 PM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 26-09
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 3503 BANK ST.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	WHITE	WIDOWED	5-3-13	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Balto.	U. S. A.

13. FATHER'S NAME: Andrew Gross

14. MOTHER'S MAIDEN NAME: Estelle Barnick

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Son (Thomas)	3512 Fleet St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 40X I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Mitral Stenosis — INTERVAL BETWEEN ONSET AND DEATH: Prior 1958
DUE TO
(B) Rheumatic Fever
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
5-13-65	Mitral Stenosis		

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
NO	—	—

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?
—		

22. I certify that (I) (this hospital) attended the deceased from 5-8 19 65 to 5-16 19 65, that (I) ~~(we)~~ last saw the deceased alive on 5-16 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☑	23B. DATE SIGNED
John D. Harrah, M.D.					5-16-65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
JOHN D. HARRAH, M D		JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	5-21-65	Security Cem.	Balto	Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 20 1965	Robert E. Fisher, M.D.	Connelly Sons - 300 Mace	(21)

VS 150-REV. 1/1/65

M-254 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5349 Registered No. 65 5349

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): McNeill, Adrian Seymour
2. DATE AND HOUR OF DEATH: 5/18/65 — 11 P. M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND
   FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Montebello State Hospital
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
   A. STATE: Maryland — B. COUNTY: 13 08
   C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
   D. STREET ADDRESS (If rural, give location): 2007 Druid Park Drive
5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 5/26/1902
9. AGE (In years last birthday): 62 — If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Aerospace-ture Builder
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): W. Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Benjamin Mc Neill
14. MOTHER'S MAIDEN NAME: Mc Neill (no relation)
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 214-07-1166
17. INFORMANT: Hospital Records. — ADDRESS:

MEDICAL CERTIFICATION

18. 163X 1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) DUE TO: Carcinomas of Lung with Metastases — INTERVAL BETWEEN ONSET AND DEATH: 1 year.
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(B) DUE TO:
(C)
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/12/65 19 to 5/18/65 19, that (I) (we) last saw the deceased alive on 5/18/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Daniel G. Lai M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 5/18/65
23C. PHYSICIAN'S NAME (Type): Daniel G. Lai M.D.
23D. ADDRESS: Montebello Hospital, Baltimore, Md. 21218

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 5-22-65
24C. NAME of CEMETERY or CREMATORY: Meadowridge
24D. LOCATION (City, town, or county) (State): Howard Co Md

25A. DATE RECD BY HEALTH DEPT.: MAY 20 1965
25B. NAME OF REGISTRAR: Robert E. Fowler, M.D.
25C. FUNERAL DIRECTOR: Grant H. Leitz
ADDRESS: 814 W. 36th St. Baltimore

VS 150-REV. 1/1/65

W-426 1

BIRTH NO. 65 5350

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5350

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Georganna C. WALKER

2. DATE AND HOUR OF DEATH: 5-16-65 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 4000 Hamilton Ave. Balto. 6. Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 27-34
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4000 Hamilton Ave. 6

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Widowed	9-4-73	91				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Buyer	Dept. Store.	New York	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Peter Baumes	Letia (Unknown)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	217 09 4727	Mr. Lewis S. Hedgepeth.	4000 Hamilton Ave. 6

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: arteriosclerotic cardiovascular — ?

(B) DUE TO: disease & cerebral accident + — 3 weeks

(C) DUE TO: Right hemiplegia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY: M.D. CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPRDX.)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from May 15 1965 to May 16 1965, that (I) (we) last saw the deceased alive on May 16 1965 and that in(my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: E.J. Alessi M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐ — 23B. DATE SIGNED: 5/18/65

23C. PHYSICIAN'S NAME (Type): ~~George Wilson~~ E.J. Alessi M.D. — 23D. ADDRESS: 6217 Harford Rd. Balto. 14, Md.

HPA 6-9922

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-19-65	Meadowridge Mem. Park Cem..	Wash.Blvd. AA Co. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 20 1965	Robert E. Talley, M.D.	Wm. Cook Brooks Inc.	6009 Harford Rd. 14 Hamilton

VS 150-REV. 1/1/65

Y-434 1

BIRTH NO. 65 5351

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 5351

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Yealdhall, Louis. M.

2. DATE AND HOUR OF DEATH: 5-18-65. 9:25 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 24-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #21230.
D. STREET ADDRESS (If rural, give location): 1504 East Fort Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M.	White.	Married.	7-28-92	72.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Superintendent
10B. KIND OF BUSINESS OR INDUSTRY: Is Married
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Yealdhall
14. MOTHER'S MAIDEN NAME: Anna Muller.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): Yes 4 June 1918 - 30 June 1919
16. SOCIAL SECURITY NO.: 090-07-1198
17. INFORMANT: Louis G. Yealdhall ADDRESS: 1504 E. Fort Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Squam Cell Carcinoma

(B) DUE TO:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes.	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-8 1965 to 5-18 1965, that (I) (we) last saw the deceased alive on 5-18 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: M.W. Kilchenstein M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 5-19-65.
23C. PHYSICIAN'S NAME (Type): M. W. KILCHENSTEIN, M.D.
23D. ADDRESS: South Balto. Gen. Hosp. - 1213 Light St.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/21/65	Baltimore National Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: MAY 20 1965
25B. NAME OF REGISTRAR: Robert E. Faherty
25C. FUNERAL DIRECTOR ADDRESS: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue

MAY 20 1965 Robert E. Faherty

VS 150-REV. 1/1/65

#-500 1

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 5352 M.E. CASE NO.

CERTIFICATE OF DEATH X

Registered No. 65 5352

1. NAME OF DECEASED (Type or Print): PHYLLIS HANNA

2. DATE AND HOUR OF DEATH: MAY 17 - 1965 6 20 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): LUTHERAN HOSPITAL BALTO. 16, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21222 5300
D. STREET ADDRESS (If rural, give location): 3701 OLD NORTH POINT ROAD

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	Wh	MARRIED	OCT. 29, 1912	52				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Pennsylvania	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Leahey	Belle Brown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	220-22-3067	Husband, Mr. Warren Hanna, # 4,a,b,c,d.	

MEDICAL CERTIFICATION

18. 154X 1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO: Adenocarcinoma, Rectum

(B) DUE TO:

(C):

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from 12 30 Am May 17 1965 to 6 20 Am May 17 1965, that (I) (we) last saw the deceased alive on 6 20 Am May 17 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
Angel H. Roque M.D.	Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑	May 17, 1965

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
ANGEL H. ROQUE M.D.	LUTHERAN HOSPITAL BALTO 16, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	May 20-1965	Oak Lawn	Eastern Ave. Bal. Co. Md. 21222

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 20 1965	Robert E. Farley, M.D	JOHN J. DUDA 7922 Wise Ave. Dundalk, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-432 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5353 Registered No. 65 5353

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MICHAEL KOLODZIEJ

2. DATE AND HOUR OF DEATH: May 18, 1965 10;30 am M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give sheet address or location): Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Edgemere
D. STREET ADDRESS (If rural, give location): 2709 Sparrows Point Road, 21219

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	Sept. 4, 1899	65		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired, Shipyard	Bethlehem Steel Co.	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Kolodziej	Theresa Kolodziej

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	213-07-8403	Wife, Mrs. Rose Kolodziej, # 4,a,b,c,d.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

		INTERVAL BETWEEN ONSET AND DEATH
I (A) DUE TO	Heart Failure	Inst.
(B) DUE TO	Art. Scl. Heart Dis	2 years.
(C)		

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

420.0

CERTIFICATION APPROVED BY: CHIEF OR ASST. MEDICAL EXAMINER, M.D.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Jan 1 1965 to May 18 1965, that (I) (~~we~~) last saw the deceased alive on March 2 1965 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
M.D.	Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐	May 18 1965

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Roger G. Windsor M.D.	520 D St. Sparrows Point, Md. 21219

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	May 22-1965	Holy Rosary Cemetery	German Hill Rd. Dundalk, Md. 22

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 20 1965	Robert E. Faulkner	JOHN J. DUDA 7922 Wise Ave. Dundalk, Md. 22

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

1-520

BIRTH NO. 65 5354

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5354

M.E. CASE NO.

33/99

1. NAME OF DECEASED (Type or Print): THOMAS JONES

2. DATE AND HOUR PRONOUNCED DEAD: 5-17-65 6:40 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): JOHNS HOPKINS HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1004 N. Chapel Street

204

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Colored	Married	10-22-79	85?				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Steel Co.	Cumberland Co., Va.	U.S.A.

13. FATHER'S NAME: Thomas Jones

14. MOTHER'S MAIDEN NAME: Ruth Tatcher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		Mrs Lillie Thomas	1004 N. Chapel

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

422.1

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: R. S. Fisher M.D.

EXAMINER'S NAME (Type): RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 5-17-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5-20-65	Mt. Calvary Cmty.	Anne Arundel Co., Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 20 1965	Robert E. Foulkrod	Randolph J. Collick	1412 E. Preston St.

VS 151-REV. 1/1/65

1

L-202

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 5355

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5355

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SAMUEL LEWIS

2. DATE AND HOUR PRONOUNCED DEAD: 5-16-65 | 5:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): JOHNS HOPKINS HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1417 E. Madison Street

33/99

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Colored			80 ?				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		Mr Annie Hayes	1346 N. Wolfe St

MEDICAL CERTIFICATION

18. 443x

CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive arteriosclerotic heart disease

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection XX Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes X Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type): Russell S. Fisher M.D. — RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER X
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 5-17-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/20/1965	Mt Calvary Cem	Brooklyn Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 20 1965	Robert E. Faber M.D.	Choy A. Wilson	1000 Brantley

VS 151-REV. 1/1/65

1

W-452

41

BIRTH NO. 65 5356

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5356

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): RICHARD WILLIAMS

2. DATE AND HOUR PRONOUNCED DEAD: May 17, 1965 9:40 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): ST. JOSEPH HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-06
D. STREET ADDRESS (If rural, give location): 1500 E. Federal Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Negro		Nov 28 1928	37				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Labor		Jamestown S Carolina	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Perry Williams	Maggie Alston

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		Lottie Lunnie	Same

MEDICAL CERTIFICATION

18. 340.3

CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Purulent meningitis

DUE TO

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type): John E. Adams M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 5-18-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/22/1965	Iron Cut S Caroline	South Carolina

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 20 1965	Robert E. Faburn	George Holman	Mounts Corner S. Carolina

VS 151-REV. 1/1/65

G-420 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5357 Registered No. 65 5357

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Gullick, McKinley O.

2. DATE AND HOUR OF DEATH: 5/18/65 | 8:59 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): LUTHERAN HOSPITAL OF MD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD. B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 17 | 3-04
D. STREET ADDRESS (If rural, give location): 3508 Woodbrook Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	Negro	Married	12/30/97	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Porter		Jessamine Co. Kentucky	U.S.A.

13. FATHER'S NAME: Abe Gullick

14. MOTHER'S MAIDEN NAME: Jane Duff

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No.

16. SOCIAL SECURITY NO.

17. INFORMANT: Chas. Mabel Gullick — ADDRESS:

MEDICAL CERTIFICATION

18. 420 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute myocardial infarction — 3 mos.
DUE TO
(B) Hypertensive and arteriosclerotic heart disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8:30 AM 5/18 1965 to 8:59 AM 5/18 1965, that (I) (we) last saw the deceased alive on 8:59 AM 5/18 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Felipe P. Pagdanganan M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ — 23B. DATE SIGNED: 5/18/65

23C. PHYSICIAN'S NAME (Type): FELIPE P. PAGDANGANAN M.D. — 23D. ADDRESS: LUTHERAN HOSPITAL OF MD

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/21/1965	Mt. Calvary Cem.	Brooklyn Md

25A. DATE REC'D BY HEALTH DEPT.: MAY 20 1965 — 25B. NAME OF REGISTRAR: Robert E. Faber M.D. — 25C. FUNERAL DIRECTOR: Elroy C. Wilson — ADDRESS: 1000 Brent Ave.

VS 150-REV. 1/1/65

1

R-200

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 5358

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5358

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) VERNON LEE ROSS	2. DATE AND HOUR PRONOUNCED DEAD May 18, 1965 10:00 P.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Franklin Square Hospital	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY — C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-01 — D. STREET ADDRESS (If rural, give location): 17 N. Payson St.

36

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
male	colored		April 3	45		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Labor		North Carolina	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Ross	Charity Bell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES		Josephine Ross	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

571.0

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fatty metamorphosis of the liver

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breitenecker M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 5-19-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/21/1965	Baltimore National Cemetery	Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 20 1965	Robert E. Farley, M.D.	Elroy O. Wilson	1001 Braniff Pl

VS 151-REV. 1/1/65

R-153 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5359 Registered No. 65 5359

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Clara Robinson.

2. DATE AND HOUR OF DEATH: 5-18-65. 8:40 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland. B. COUNTY: aa
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Glen Burnie
D. STREET ADDRESS (If rural, give location): 6210 Flamingo Drive.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F.	Negro.	Widow.	9-17-00	65.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		York W. Va.	U S A

13. FATHER'S NAME: Wm. Thomas.

14. MOTHER'S MAIDEN NAME: Adeline. Rastemy

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.		Cora Nettles	Same.

MEDICAL CERTIFICATION

18. 434.1

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH
(A) DUE TO: Bronchopneumonia
(B) DUE TO: Congestive Heart Failure
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES.	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPRDX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from 5-15 1965 to 5-18 1965, that ~~I~~ (we) last saw the deceased alive on 5-18 1965 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: W. Douglas Weir, M.D. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED: 5-18-65

23C. PHYSICIAN'S NAME (Type): W. Douglas Weir, M. D. M.D. 23D. ADDRESS: South Baltimore General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/22/1965	Mt Calvary Cem	Brooklyn Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR / ADDRESS
MAY 20 1965	Robert E. Fahey	Elroy D. Wilson - 1002 Brantly Rd

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

C-616

BIRTH NO. 65 5360

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5360

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)	2. DATE AND HOUR PRONOUNCED DEAD
MAYFIELD CRAWFORD	5-16-65 6:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)	A. STATE Maryland B. COUNTY
443 Orchard Street	C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 11-03
	D. STREET ADDRESS (If rural, give location) 443 Orchard Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	Colored	Sep	12/21/09	55				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		South Carolina	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frank Crawford	Mary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs Ernestine Hayden	414 Pinaire Rd,

MEDICAL CERTIFICATION

18. 422.1

CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECENDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy XX and that on this basis, death in my opinian resulted from: Natural causes X Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE R S Fisher M.D.

EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER X

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 5-17-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/22/65	Mt Calvary	a. a. County Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 20 1965	R. L. & E. Farley M.D.	Adolphus Holstead	1718 Druid Hill Ave

VS 151-REV. 1/1/65

R-153 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5361 Registered No. 65 5361

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Elizabeth ~~Xxxxxxxx~~ Robinson

2. DATE AND HOUR OF DEATH: 5-19-65 | 9:30 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 27-38
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 6128 Marlora Rd.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	~~M~~ Widowed	11-24-78	86				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home		Maryland	USA

13. FATHER'S NAME: DAVIS George

14. MOTHER'S MAIDEN NAME: Mary Hopkins

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	none	Evelyn E. Cramblitt	same

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 4221 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO: CVA — INTERVAL BETWEEN ONSET AND DEATH
(B) DUE TO: ASCVD c dehydration (Bronchopneumonia)
(C): arterial embolism Clex-Heart

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
None			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (only medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None		

21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?
None		

22. I certify that (I) (this hospital) attended the deceased from 4/26/65 1965 to 5/19 1965, that (I) (we) last saw the deceased alive on 5/19 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
Wm E Schwartz					5/19/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Wm E. SCHWARTZ		Mercy Hosp Balto

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	5-22-65	Spring Hill Cemetery	Easton, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 20 1965	Robert E. Farley M.D.	Leonard J. Ruck Inc Baltimore, Md.

VS 150-REV. 1/1/65

F-523 1

BIRTH NO. 65 5362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5362

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Beatrice M. Forster

2. DATE AND HOUR OF DEATH: WED. 5-19-65 | 10:35 AM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location): South Baltimore General Hosp. 153

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 65/2780/187
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore # 21230.
D. STREET ADDRESS (If rural, give location): 1521 S. Race St. 2-302

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: JAN 9-1902
9. AGE (In years last birthday): 63
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife.
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Cooper.
14. MOTHER'S MAIDEN NAME: Catherine Tutor.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: ROLAND G. FORSTER - HUSBAND ADDRESS (Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Carcinoma of Floor of Mouth

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO:

(C):

INTERVAL BETWEEN ONSET AND DEATH:

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES.
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from 5-1 19 65 to 5-19 19 65, that ~~I~~ (we) last saw the deceased alive on 5-19 19 65 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: M. W. Kilchenstein M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 5-19-65
23C. PHYSICIAN'S NAME (Type): M. W. Kilchenstein M.D.
23D. ADDRESS: South Baltimore General Hospital 65/2780/187

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: MAY SAT. 22 1965
24C. NAME of CEMETERY or CREMATORY: LOUDON PARK CEM - BALTIMORE, MD
24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.: MAY 20 1965
25B. NAME OF REGISTRAR: Robert E. Faherty M.D.
25C. FUNERAL DIRECTOR: CURTIS E. EVANS ADDRESS: 1400 SCHAEFER ST. BALTO. MD 21230

VS 150-REV. 1/1/65

CURTIS E. EVANS

43-13-51 IB 1

B-200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5363 Registered No. 65 5363

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): George Beck

2. DATE AND HOUR OF DEATH: 5-16-65 8 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pennsylvania
B. COUNTY: V-35
C. CITY OR TOWN (If outside city limits, write RURAL and give township): New Castle
D. STREET ADDRESS (If rural, give location): R D # 2

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Divorced	9-13-18	46				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck Driver		Michigan	USA

13. FATHER'S NAME: Lawrence Beck

14. MOTHER'S MAIDEN NAME: Mae Dickerson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	WW2	unknown	RECORDS-BCH-4940 Eastern Avenue - #21224	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the diseose, injury or complicotion which coused deoth.)

(A) Respiratory Arrest — Minutes

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the obove couse (A) stating the UNDERLYING CONDITION lost.

DUE TO (B) Pneumonia, probable Bronchogenic Carcinoma — Months

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: White At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-20 1965 to 5-16 1965, that (I) (we) last saw the deceased alive on 5-16 19 65 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: C. Carpenter M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ — 23B. DATE SIGNED: 5-16-65

23C. PHYSICIAN'S NAME (Type): Dr. Charles Carpenter M.D. — 23D. ADDRESS: 4940 Eastern Avenue - #21224

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	May 17/65	Mt. Hill Cem	Galeton Pa

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 20 1965	Robert E. Farley M.D.	Philip Hennig Sons	2024 Eutaw St

VS 150-REV. 1/1/65

31

S-62 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5364 Registered No. 65 5364

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Schwarzkopf, Adelaide

2. DATE AND HOUR OF DEATH: May 19, 1965 4:50 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): St. Joseph Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY 7-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21205
D. STREET ADDRESS (If rural, give location): 700 N. Montford Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Married	1-29-1904	61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Homemaker	----	Baltimore, Maryland	

13. FATHER'S NAME: Vincente Edward Vincente

14. MOTHER'S MAIDEN NAME: Agnes Ammel

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
---	---	---	Mr. Albert H. Schwarzkopf,	900 N. Montford Ave

MEDICAL CERTIFICATION

1B. 163 I — CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not meon the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complicotion which caused death.)

(A) Bilateral lymphangitic carcinoma of lungs.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Boltimore City, give exoct locotion)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospitol) ottended the deceosed from May 11, 1965 to May 19, 1965, thot (I) (we) last saw the deceosed olive on May 19, 1965 ond that in (my) (our) opinion deoth occurred on the dote ond hour and from the couses stoted above. (I) (We) (did) (did not) view the body ofter deoth.

23A. SIGNATURE: Wm B VandeGrift M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. X

23B. DATE SIGNED: May 20, 1965

23C. PHYSICIAN'S NAME (Type): William B. VandeGrift, M.D.

23D. ADDRESS: 1400 N. Caroline St., Baltimore, Md. 21213

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	May 22/65	Moreland Mem. Park	Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
		Philip Herwig Sons	2024 Orleans St. 31

VS 150-REV. 1/1/65

G-640 1

S-327

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 5365

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5365

1. NAME OF DECEASED (Type or Print): Ann Grail (Sr. Anne De. St. Jacques)

2. DATE AND HOUR OF DEATH: May 18, 1965 at 7:30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): The Seton Psychiatric Institute
6420 Reisterstown Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: District of Columbia
B. COUNTY: V-48
C. CITY OR TOWN (If outside city limits, write RURAL and give township):
D. STREET ADDRESS (If rural, give location): 220 H Street N.E.

17

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Never Married	Feb. 8, 1882	83		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Catholic Nun		France	France

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jacques Grail	Annette Monterimard

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	Hospital records	

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
542 X 1	(A) Chronic Myocardial Degeneration	8 years
	DUE TO (B) Coronary and General Arteriosclerosis	about 15 years
	(C) Chronic Glomerulonephritis	?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Psychotic Depressive Reaction (recurrent)	8 years

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from July 13 19 57 to May 18 19 65, that (I) (we) last saw the deceased alive on May 18 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
Walter O. Jahrreiss M.D.	Attending Phys. ☐ for Med. Director ☑ Staff Phys. ☐	May 18, 1965

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Walter O. Jahrreiss M.D.	6420 Reisterstown Road, Baltimore, Maryland

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/21/65	Cathedral	Baltimore

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 20 1965	Robert E. Farber, M.D.	Philip Henry & Sons	Orleans 2274

VS 150-REV. 1/1/65

S-6301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65-11826 65 5366 M.E. CASE NO.

Registered No. 65 5366

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Sherrod, baby boy of Edna

2. DATE AND HOUR OF DEATH: May 14, 1965 — 5:15p M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Provident Hospital, 1514 Division Street, Baltimore, Maryland 21217

39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 16-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1330 W. Mosher Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Negro	single	May 14, 1965				5	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Maryland	U.S.A.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME: Edna Sherrod

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Edna Sherrod-mother	same

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

I 176X
(A) Immaturity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH: 5hrs.(approx.)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		no	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 14, 1965 to May 14, 1965, that (I) (we) last saw the deceased alive on May 14, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Vincent R. Blake M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: May 14, 1965

23C. PHYSICIAN'S NAME (Type): Vincent R. Blake M.D.

23D. ADDRESS: 1514 Division Street-Baltimore, Maryland

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE: MAY 19 1965

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town or county) (State)

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL

25A. DATE REC'D BY HEALTH DEPT.: MAY 20 1965

25B. NAME OF REGISTRAR: Robert E. Faulkner

25C. FUNERAL DIRECTOR: MORTUARY SERVICE - BCHD

ADDRESS

VS 150-REV. 1/1/65

M-24 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65-10942-65 5367 Registered No. 65 5367

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): McElveen, baby of Joyce

2. DATE AND HOUR OF DEATH: May 14 1965 | 5:30 a M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): Provident Hospital, 1514 Division Street, Baltimore Maryland 21217

4. USUAL RESIDENCE (Where deceosed lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give locotion): 421 Cummings Court

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	Negro	single	May 9 1965		5	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	none	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Eric McElveen	Joyce Wallace

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Joyce McElveen-mother	same

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Bronchopneumonia	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	DUE TO (B) Intracranial bleeding (left frontal lobe)	
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Prematurity	

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		yes	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 9 1965 19 to May 14 1965 19, that (I) (we) last saw the deceased alive on May 14 1965 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
M. Behrooz	M.D.				May 17 1965

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
M. Behrooz	1514 Division Street - Baltimore Maryland

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
	MAY 19 1965	ANATOMY BOARD OF MARYLAND	

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 20 1965	R. L. S. E. Faikeyrd	UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD	

VS 1S0-REV. 1/1/65

L-520 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65-11804 65 5368 Registered No. 65 5368

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Baby ~~of Dorothy~~ Lynch

2. DATE AND HOUR OF DEATH: May 11, 1965 | 1:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital, 1514 Division Street, Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 16-04

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1134 Monroe Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Negro	Single	May 10, 1965				16	15

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jimmy Dickens	Dorothy Lynch

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 762.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Neonatal atelectasis at birth — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO:

(C):

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Prematurity.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 10, 1965 19 to May 11, 1965 19, that (I) (we) last saw the deceased alive on May 11, 1965 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
M. Behrooz M.D.	Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒	5-12-65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
M. Behrooz M.D.	1514 Division Street

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town or county) (State)
	MAY 19 1965		

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 20 1965	Robert E. Farley M.D.		

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

W-416

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5365 — Registered No. 65 5369

1. NAME OF DECEASED (Type or Print): WALLACE WOOLFORD

2. DATE AND HOUR PRONOUNCED DEAD: 5-10-65 | 12:40 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): PROVIDENT HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1508 W. Fayette Street 21223

1902

39
99

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months / Days / Hours / Min.
Male	Colored	Married	5-5-1905	56	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Construction	Newton Md	USA

13. FATHER'S NAME: John Woolford

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes 22-9-43 1-12-45	214091500	Shirley Tittle	Rocks Md

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. 581.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) DUE TO	Fatty liver	
ANTECENDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Dyke W. Rieckert M.D.

EXAMINER'S NAME (Type) PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED 5-10-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
BURIAL	5-17-65	Baltimore National	Baltimore City Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 20 1965	Robert E. Farley M.D.	George W Tittle Bel Air, Md

VS T51-REV. 1/1/65

H-5370 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5370 Registered No. 65 5370

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Julia Hammett

2. DATE AND HOUR OF DEATH: May 19, 1965 | 4½ o'clock A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location): George Washington Carver N.H. 607 Pennsylvania avenue.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 2-21
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 12 W. Hill Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	Negro	Widowed	6/30/1891	74				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
?	?	S. C. ?	U.S.

13. FATHER'S NAME: Dan Mills

14. MOTHER'S MAIDEN NAME: Lucy? Nelson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
?		?	C # 601	607 N. Pennsylvania Ave.

MEDICAL CERTIFICATION

18. 287 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO: Cerebro vascular accident

(B) DUE TO: hypertensive arteriosclerotic ?

(C) Hypertensive renal disease Obesity

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 30 1963 to May 18 1963, that (I) (we) last saw the deceased alive on May 18 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☑	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
M. Mac Murchy					May 19/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
J.N. MacMurchy		500 E Madison St. Balto. 2 Md

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	5/21/65	Lumter	S.C.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 20 1965	Robert E. Tarbert M.D.	Isaiah W. Brown & Son	123 W. MONTGOMERY ST.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-4601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5371 Registered No. 65 5371

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ROSARIO FERRARA OR FERRARO

2. DATE AND HOUR OF DEATH: MAY 18 1965 8.45 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or locotion): Mercy Hospital

4. USUAL RESIDENCE (Where deceosed lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: BALTO.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rurol, give locotion): 355 S. SPRING COURT.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In yeors lost birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	W	SEPT. 29 1892	73				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	STONE MASON	ITALY	ITAN

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
VINCENT FERRARA	PAULINE TORCHIA

15. Was Deceosed Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give wor or dotes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	218-09-1105	MRS. PAULINE CERQUETTI	5308 Beauford AVE

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart foilure, osthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cardiac Arrythmia — Recent
DUE TO
(B) Myocardial infarct " + old
DUE TO
(C) ASCVD —

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above couse (A) stoting the UNDERLYING CONDITION last.

420.1 I

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
none		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Will medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
none		

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
none	While At Work ☐ Not While At Work ☐	

22. I certify thot (I) (this hospitol) attended the deceosed from ____ 19 ____ to May 8 19 65, thot (I) (we) last sow the deceosed alive on May 18 19 65 ond that in (my) (our) opinion death occurred on the date and hour ond from the couses stoted above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Wm E Schwartz M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ — 23B. DATE SIGNED: 5/18/65

23C. PHYSICIAN'S NAME (Type): WM E. SCHWARTZ M.D. — 23D. ADDRESS: Mercy Hosp Balto

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/22/65	HOLY REDEEMER	4409 BELAIR RD. BALTO. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 20 1965	Robert E. Farley, M.D.	Frank Della Noce	322 s. High St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-26 01

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5372 Registered No. 65 5372

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ELLA DORA BAKER

2. DATE AND HOUR OF DEATH: 5 18 65 | 3:15 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST AGNES HOSPITAL

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): ELLICOTT CITY 53-00
D. STREET ADDRESS (If rural, give location): WEST CHESTER AVE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	WHITE	WIDOWED	4-10 81	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE		MARYLAND	U.S.A.

13. FATHER'S NAME: [illegible] SOUDER

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): NONE

16. SOCIAL SECURITY NO.:

17. INFORMANT: ST. AGNES HOSPITAL RECORDS; CATON & ADDRESS WILKENS AVES

CERTIFICATION APPROVED BY: Charles Lee M.D. CHIEF OR ASSOC. MEDICAL EXAMINER. 5/19/65

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Myocardial Infarction due to Left Ventricl & Septum. — INTERVAL BETWEEN ONSET AND DEATH: 1-2 days.

(B) Fracture of hip. Rt due to — 21 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C) 420.1 + E 903.0

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
35-4-1965	Fracture of hip	X Yes	Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING [X] CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
yes	Home	Ellicott City

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work [ ] Not While At Work [X]	21F. HOW DID INJURY OCCUR?
4 27-65 4 30 pm		Fell. to floor

22. I certify that (I) (this hospital) attended the deceased from APRIL 27 19 65 to MAY 18 19 65, that (I) (we) last saw the deceased alive on MAY 18 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
Carl H Matthey		[ ]	[ ]	[X]	5-18-65

23C. PHYSICIAN'S NAME (Type): CARL H. MATTHEY M.D.

23D. ADDRESS: ST. AGNES HOSPITAL; CATON & WILKENS AVES #29

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
	5-21-65	Emmanuel, Scaggsville,	Scaggsville, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 20 1965	Robert E. Farley M.D.	Harry H. Witzke, 321 Columbia Pike, Ellicott City, Md.

VS 150-REV. 1/1/65 * Autopsy Permission given by family - Medical Examiner

N820

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

L-163

BIRTH NO. 65 5373

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5373

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BETTY LOIS LAPRADE	2. DATE AND HOUR PRONOUNCED DEAD: May 12, 1965 12:40 a M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Lutheran Hospital	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: 15-10 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore D. STREET ADDRESS (If rural, give location): 3828 BARRINGTON Rd

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.
female	white	MARRIED	12-27-1933	31	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
WAITRESS		UNKNOWN	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
UNKNOWN	UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	Yes	Lewis Laprade - 3828 BARRINGTON Rd

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A)	Stab wound of heart	
DUE TO (B)		
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	House	3828 Barrington Road

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
5 11 65 10:40p.m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Stabbed during altercation

22. I certify that I held on Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 5-12-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5-15-65	Woodlawn Cemetery	Baltimore, Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 20 1965	R. L. & E. Fasbury M.D.	Ellsworth Armacost — Ellsworth Armacost — 4600 Liberty Heights

VS 151-REV. 1/1/65

A 961.2

1

R-200

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 65 5374 Registered No. 65 5374

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HAROLD ROOKS

2. DATE AND HOUR PRONOUNCED DEAD: May 17, 1965 8:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): SOUTH BALTIMORE GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-03
D. STREET ADDRESS (If rural, give location): 522 N. Schroeder Street

43

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Negro	DIVORCED	9-21-1920	44				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RIGGER	McDADE Co.	BALTIMORE MD	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
McALLISTER ROOKS	DEARY L. CHOICE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	217-09-7295	HENRY ROOKS	522 N. SCHROEDER ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) DUE TO: Lobar pneumonia	
ANTECENDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO:	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Fatty metamorphosis of the liver	

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type): John E Adams M.D. / John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 5-18-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/22/65	Mt Calvary	Brooklyn - Bal Co. Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 21 1965	Robert E. Farley M.D.	Maryland P. Hayes	638 W Gilmor St

VS 151-REV. 1/1/65

S-157 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5375 Registered No. 65 5375

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GOLDIE SPENCER

2. DATE AND HOUR OF DEATH: May 17 - 1965 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): FRANKLIN Sq. Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD B. COUNTY: 19-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1611 W. LEXINGTON St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FE	Colored	SEPARATED	6-29-1916	48		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	FLORENCE - S.C.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
GOLDEN JACKSON	MARTHA JACKSON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		WILLIE M. WRIGHT -	802 N. PAYSON St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

I (A) DUE TO: Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 months

(B) DUE TO:

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9/30 19 64 to 5/17 19 65, that (I) (we) last saw the deceased alive on 5/17/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Ralph W. Kelly M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐ — 23B. DATE SIGNED: 5/20/65

23C. PHYSICIAN'S NAME (Type): Ralph W. Kelly M.D. — 23D. ADDRESS: 420 N. Gilmor Street

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/20/65	Baltimore National	Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 21 1965	Robert E. Farley, M.D.	Marshall P. Hays	638 N. Gilmor St

VS 150-REV. 1/1/65

L-500 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5376 Registered No. 65 5376

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Ernest Lane

2. DATE AND HOUR OF DEATH May 16, 1965 | 6:50 a.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion) Provident Hospital 1514 Division Street Baltimore, Maryland

39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY 15-01

C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rurol, give locotion) 1128 Laurens Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In yeors lost birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Negro	Divorced n	10-17-1899	65				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
?		Calvert Co., Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
?	?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	717-09-0171	Hospital Chart	

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 4148 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO Pulmonary Edema

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if ony, giving rise to the obove cause (A) stoting the UNDERLYING CONDITION last.

(B) DUE TO Rheumatic Valvulitis (old)

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cirrhosis of Liver (Laenec)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes.	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Boltimore City, give exoct locotion)

21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify thot (I) (this hospital) ottended the deceased from May 15, 1965 19 to May 16, 1965 19, thot (I) (we) lost saw the deceased olive on May 16, 1965 19 ond that in (my) (our) opinion death occurred on the date and hour and from the couses stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
R. Blackmon					May 18, 1965

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Robert Blackmon		1514 Division Street

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/20/65	Mt Calvary Cemetry	A A County Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 21 1965	Robert E. Farley M.D.	Adolphus Halstead	918 Druid Hill Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

0-520

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 5377

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5377

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARJORIE OWENS

2. DATE AND HOUR PRONOUNCED DEAD: May 17, 1965 5:10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): MARYLAND GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 1302
D. STREET ADDRESS (If rural, give location): 2235 Eutaw ~~Street~~ Place

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	Negro	Separated	April 15, 1907	58				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
cook		Johnson City Tenn	

13. FATHER'S NAME: Floyd Smith

14. MOTHER'S MAIDEN NAME: Lillian

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		Mrs Lillian A Locksley 7918 Golden St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Cleveland O. — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Kyphoscoliotic heart disease

DUE TO

ANTECENDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Cirrhosis of liver

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type): John E. Adams M.D.

M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 5-18-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/21/65	Mt Auburn Cemetery	Balto., Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 21 1965	Robert E. Farley M.D.	A. Halstead 1206 W. North Ave.

VS 151-REV. 1/1/65

H-560 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5378 Registered No. 65 5378

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): James Henry

2. DATE AND HOUR OF DEATH: 18 MAY 1965 | 2:05 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 107 Albermarle St Flag Court

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	N		7-18-91	84				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		NEW YORK	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
DAVID HENRY	MARY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Hospital Chart	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not meon the mode of dying, e.g., heort foilure, osthenio, etc. It means the disease, injury or complicotion which coused deoth.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if ony, giving rise to the obove couse (A) stoling the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
I	(A) DUE TO: Upper Gastrointestinal Hemorrhage	3 days
	(B) DUE TO:	
	(C)	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Intestinal Obstruction, Gangrene of Leg

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
5-6-65 5-7-65	Intest. Obstruction Gangrene of Leg	yes	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical exominer)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exoct locotion)

21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-3-65 19 to 5-18-65 19, that (I) (we) last saw the deceased alive on 5-18-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☑	23B. DATE SIGNED
Theodore G. Dodenhoff					5-18-65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
T. G. Dodenhoff		University Hospital Baltimore

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/21/65	Mt Auburn Cemetry	Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 21 1965	Robert E. Talbert M.D.	Adolphus Halstead	918 Druid Hill Ave

VS 150-REV. 1/1/65

G-65-4 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5379 Registered No. 65 5379

1. NAME OF DECEASED (Type or Print): Miss Helen V. Greenholt

2. DATE AND HOUR OF DEATH: 5/16/65 | 4PM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Gould Convalescarium 6116 Belair Rd Baltimore #6 Md

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 27-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2815 Talsa Ave

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W		7-10-1890	74				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	own home	Maryland	USA

13. FATHER'S NAME: George Greenholt

14. MOTHER'S MAIDEN NAME: May Fuhrman

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Helen Methkin Md ADDRESS: Ave Towson Md

MEDICAL CERTIFICATION

18. 163X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH
(A) Carcinoma of the Lung
DUE TO
(B) with Carcinomatosis
~~DUE TO~~
(C)

INTERVAL BETWEEN ONSET AND DEATH
3 years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Sept 1949 to 5/16 1965, that (I) (~~we~~) last saw the deceased alive on 5/15/65 19 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Martin L. Singewald M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐ 23B. DATE SIGNED: 5/18/65

23C. PHYSICIAN'S NAME (Type): MARTIN L. SINGEWALD M.D. 23D. ADDRESS: 11 E. CHASE ST BALTIMORE 2 Md

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of ~~CEMETERY~~ or CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	5-20-65	Greenmount	Balto Md

25A. DATE REC'D BY HEALTH DEPT.: MAY 21 1965 25B. NAME OF REGISTRAR: Robert E. Faber M.D. 25C. FUNERAL DIRECTOR: Tipton-Eline-Hempstead MD ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-636 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5380 Registered No. 65 5380

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Arthur, Adelaide

2. DATE AND HOUR OF DEATH: May 19, 1965 | 5.00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Provident Hospital, Inc.

39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY
1328 W. Lanvale Street
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, Maryland 21217
D. STREET ADDRESS (If rural, give location): 16-02

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	Negro	Single	2-4-16	49				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Virginia	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Un Known	Un Known

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Alfreda Veniey	same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not meon the mode of dying, e.g., heart foilure, osthenio, etc. It meons the diseose, injuiy or complicotion which coused deoth.)

(A) Complete Heart Failure
DUE TO

(B)
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if ony, giving rise to the obove couse (A) stoting the UNDERLYING CONDITION lost.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or obout home, lorm, foctory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Boltimore City, give exoct locotion)

21D. TIME OF INJURY (Month) (Doy) (Yeor) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-17 19 65 to 5-19 19 65, that (I) (we) last saw the deceased alive on 5-19 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
Hollis Seunarine, M.D.					5-19-65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Hollis Seunarine M.D.	Provident Hospital, Inc.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	5-22-65	Mt. Auburn Cem	Baltimore	Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 21 1965	Robt E. Talbert	Sullivan Funeral Home 1011-13	N. Arlington Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-536 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5381 — Registered No. 65 5381

1. NAME OF DECEASED (Type or Print): Nola M. Winterly
2. DATE AND HOUR OF DEATH: 5/19/65 — 1:30 A.M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND
   FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 911 W. Barre St.
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
   A. STATE: Md — B. COUNTY: 21-01
   C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
   D. STREET ADDRESS (If rural, give location): 911 W. Barre St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Married	5/3/1894	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	at home	Balto Md.	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Hampton	Bertie May Charles

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	—	—	Mr Joseph Winterly	-above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not meon the mode of dying, e.g., heart failure, asthenio, etc. It meons the disease, injury or complication which coused deoth.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if ony, giving rise to the abave couse (A) stating the UNDERLYING CONDITION lost.

		INTERVAL BETWEEN ONSET AND DEATH
I (A) DUE TO	Carcinoma of Stomach	6 months
(B) DUE TO	Diabetes Mellitus	7 Years
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Arter osclerotic Cardio Vascular Disease	10 Years

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0	—	No	—

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?
—	—	—

22. I certify thot (I) (~~this hospital~~) attended the deceased from 27 October 1958 to 19 May 1965, that (I) (~~we~~) last saw the deceased alive on 18 May 1965 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the couses stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
Edward F. Milan		☑	☐	☐	19 May 1965

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS M.D.
EDWARD F. MILAN	682 WASHINGTON BLVD BALTO MD

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/22/65	London Park Cem.	Baltimore Md. 21230

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 21 1965	Robert E. Foos M.D.	John J. Cowan + Sons Inc.	2 Wilkins St. 23, Md.

VS 150-REV. 1/1/65

L-535 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5382 Registered No. 65 5382

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LINDENBERGER, JOHANNA T.

2. DATE AND HOUR OF DEATH: 5-18-65 | 1:10PM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 26-11
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 926 HIGHLAND AVENUE #24

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	NEVER MARRIED	7-6-04	60				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Superviser	C+P Telephone Co.	Baltimore Maryland	U.S.A.

13. FATHER'S NAME: HENRY LINDENBERGER

14. MOTHER'S MAIDEN NAME: ELIZABETH SCHAEFER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No ———	212-09-0011	Margaret B. Lindenberger	926 S. Highland Ave,

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I 70 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) METASTATIC CARCINOMA OF BREAST	1 YEAR
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		YES	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-8-65 19 to 5-18-65 19, that (I) (we) last saw the deceased alive on 5-18-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☐ XX	23B. DATE SIGNED
James F. Fries					5-18-65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
JAMES F. FRIES		THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-21-65	Holy Redeemer Cemetery	4430 Belair Road Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 21 1965	Robert E. Faulkner M.D.	Charles S. Zeiler	901 S. Conkling St. #24

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-435 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5383 Registered No. 65 5383

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Mrs. Gertrude Isobel Clayton

2. DATE AND HOUR OF DEATH: May 19, 1965 | 9.30 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 849 Wellington Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 206
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 849 Wellington Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widow	Jan. 5, 1874	91		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home		England	U S A

13. FATHER'S NAME: ---------- Duffell

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		----------	Mrs. Florence C. Smith	849 Wellington Street

MEDICAL CERTIFICATION

18. 422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Arteriosclerotic CVD — INTERVAL BETWEEN ONSET AND DEATH: 5 years

DUE TO

(B) Congestive heart failure — 2 days

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 10 1959 to May 19 1965, that (I) (we) last saw the deceased alive on May 19 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE				23B. DATE SIGNED
Leonard Wallenstein M.D.	Attending Phys. ✓	Med. Director ☐	Staff Phys. ☐	

23C. PHYSICIAN'S NAME (Type): LEONARD WALLENSTEIN M.D.

23D. ADDRESS: 848 W 36th St Balto Md

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	May 22, 1965	Parkwood	Baltimore Co., Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 21 1965	Robert E. Farley M.D.	Burgee Funeral Home Horace A. Burgee	3631 Falls Road

VS 150-REV. 1/1/65

1

H-512

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 65 5384 Registered No. 65 5384

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CHARLES W. HEINBAUCH, SR.

2. DATE AND HOUR PRONOUNCED DEAD: May 17, 1965 11:50 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): ST. AGNES HOSPITAL

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY 44
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 52-00
D. STREET ADDRESS (If rural, give location): 3520 Annapolis Road

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Divorced	Feb. 24, 1908	57				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Caretaker		Maryla nd	USA

13. FATHER'S NAME: Albert Neubert

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-09-5899

17. INFORMANT: Charles W. Heinbauch ADDRESS: 1205 Furnace Road, Linthicum Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Noturol couses ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type): John E. Adams M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 5-18-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/21/65	Meadowridge Memorial	Elkridge, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 21 1965	Robert E. Farley M.D.	Kirkley Funeral Home, Glen Burnie

VS 151-REV. 1/1/65

H-6721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5385 Registered No. 65 5385

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Elizabeth V. Hargest

2. DATE AND HOUR OF DEATH: May 18-1965 | M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location): Gould Convelesariym

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 28-04
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rurol, give location): 4732 Amberly Ave

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W.	Wid	Jan 27-1893	72				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret Sec.		Baltimore	U.S.A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Vorsteg	Mary E Hayes

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	215-01-7469	Wm Hilbinger	2717 Louis Ave-14

MEDICAL CERTIFICATION

18. 153.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO	Metastatic Carcinoma	6 mon
(B) DUE TO	Carcinoma of Cecum	1 year
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify thot (I) (this hospitol) ottended the deceosed from March 20 1965 to May 18 1965, thot (I) (~~we~~) last sow the deceosed olive on May 17 1965 ond thot in (my) (~~our~~) opinion deoth occurred on the dote and hour ond from the causes stoted obove. (I) (~~We~~) (~~did~~) (did not) view the body ofter deoth.

23A. SIGNATURE	M.D.	Attending Phys. ✓	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
Adam G Swiss					May 19, 1965

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
ADAM G. SWISS		6232 Belair Road Balto. 6, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/21/65	Balto Nat Cem	Balto Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 21 1965	Robert E. Farley, M.D.	Lassahn Fun'l Home	7401 Belair Rd.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-452 1

BIRTH NO. 65 5386

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5386

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print)	Seneh I. Collins
2. DATE AND HOUR OF DEATH	May 19, 1965 | 2.30 A. M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	19 W. West St.
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	Maryland
B. COUNTY	23-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township)	Baltimore
D. STREET ADDRESS (If rural, give location)	19 W. West St.
5. SEX	female
6. RACE	white
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	married
8. DATE OF BIRTH	June 28, 1924
9. AGE (In years last birthday)	40yrs.
If Under 1 Yr. Months / Days	
If Under 24 Hrs. Hours / Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Sorter
10B. KIND OF BUSINESS OR INDUSTRY	Hol-tite Rubber
11. BIRTHPLACE (State or foreign country)	Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?	U.S.A.
13. FATHER'S NAME	Joseph Smith
14. MOTHER'S MAIDEN NAME	Anna Marie Schuck
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	no
(If yes, give war or dates of service)	none
16. SOCIAL SECURITY NO.	219-18-1516
17. INFORMANT	Walter R. Collins
ADDRESS	19 W. West St.

MEDICAL CERTIFICATION

18. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 - 4 hours

DUE TO

(B) Hypertensive cardio-vascular Dis. 2/19/60

DUE TO

(C) Cerebral disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)	no
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED — While At Work ☐ Not While At Work ☐	
21F. HOW DID INJURY OCCUR?	

22. I certify that (I) (this hospital) attended the deceased from 2/19 1960 to 5/19 1965, that (I) (we) last saw the deceased alive on 5/18 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	Harry Deibel M.D.
Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐	
23B. DATE SIGNED	5/20/65
23C. PHYSICIAN'S NAME (Type)	HARRY DEIBEL M.D.
23D. ADDRESS	1236 Hanover St Balto 30

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)	
Burial	5/22/65	New Cathedral Cemetery	Old Frederick Rd. Balto. Md	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS	
MAY 21 1965	Robert E. Faulkner	KRAUSE FUNERAL HOME	1216 S. Charles St	

VS 150-REV. 1/1/65

D-120 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5387 Registered No. 65 5387

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): DAVIS, RALPH HAROLD

2. DATE AND HOUR OF DEATH: 5-18-65 6:05A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 40 ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: HOWARD
C. CITY OR TOWN (If outside city limits, write RURAL and give township): WESTFRIENDSHIP, MARYLAND 6300
D. STREET ADDRESS (If rural, give location):

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
MALE	WHITE	NEVER MARRIED	12-23-47	17				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
STUDENT		MARYLAND	

13. FATHER'S NAME: CHARLES DAVIS

14. MOTHER'S MAIDEN NAME: G. CARLENE LUMSDEN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	If yes, give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		?	ST. AGNES RECORDS	-CATON & WILKENS AVE

MEDICAL CERTIFICATION

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
1B. 493X I	(A) DUE TO: Encephalitis	
	(B) DUE TO: Pneumonia	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from MAY 8 19 65 to MAY 18 19 65, that (I) (we) last saw the deceased alive on MAY 18 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
M.D.	Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒	5-18-65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
DR. HEREDIA M.D.	#29 ST. AGNES HOSPITAL; CATON & WILKENS AVE

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5-22-1965	GALVA	GALVA, IOWA

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 21 1965	Robert E. Farber M.D.	F.C. HIGINBOTHOM	ELLICOTT CITY, MD.

VS 150-REV. 1/1/65

B-6201 1

BIRTH NO. 65-13864 65 5388

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5388

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): BABY BOY BURRISS (GERALD EDWARD BURRISS)

2. DATE AND HOUR OF DEATH: 5-17-65 | 2:55 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST AGNES HOSPITAL-CATON & WILKENS

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: ST AGNES HOSPITAL
B. COUNTY: Addr 4-63-64
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, Md Ellicott City
D. STREET ADDRESS (If rural, give location): Shipads Lane

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
MALE	WHITE	INFANT	5-15-65			2		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE	NONE	MARYLAND	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
AUBREY BURRISS	SHIRLEY MAY TOWNSEND

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		NONE	ST AGNES HOSPITAL-CATON & WILKENS AVES	

MEDICAL CERTIFICATION

18. 762.5 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO: Pulmonary Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 24-48 hrs

(B) DUE TO: Prematurity

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from MAY 15 19 65 to MAY 17 19 65, that (I) (we) last saw the deceased alive on MAY 17 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
Marston Young		☐	☐	☒	5-18-65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
DR. YOUNG	M.D. ST. AGNES HOSPITAL; CATON & WILKENS AVE. #29

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-19-1965	Good Shepherd	Ellicott City, Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 21 1965	Robert E. Falkenhan	F.C. Higinbothom, Ellicott City, Md

VS 150-REV. 1/1/65

S-600 1

BIRTH NO. 65 5389

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5389

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Bernard Shear

2. DATE AND HOUR OF DEATH: 5-19-65 | 5:30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Sinai Hosp of Balto

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 27-17
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO
D. STREET ADDRESS (If rural, give location): 5013 PEMBRIDGE Ave

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	M	12-4-18	46		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
OPTICIAN		New York	USA

13. FATHER'S NAME: SAMUEL

14. MOTHER'S MAIDEN NAME: GOLDIE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No —

16. SOCIAL SECURITY NO.: 219-05-7661

17. INFORMANT: BETTY SHEAR ADDRESS: 5031 PEMBRIDGE AVE

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 260 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO	Acute Myocard. Infarction	10 hrs?
(B) DUE TO	Arteriosclerotic Car. disease	?
(C)	Diabetes Mell. tus	30 yrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. O

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
O	O	NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
NO		

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-19 12 50 PM 19 65 to 5-19-65 5 30 PM 19 65, that (I) (we) last saw the deceased alive on 5-19-65 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
H. Gerald Oster M.D.	Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑	5/19/65

23C. PHYSICIAN'S NAME (Type) H. GERALD OSTER M.D. 23D. ADDRESS: Sinai Hosp. of Balto.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/20/65	Rosedale	Balto Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 21 1965	Robert E. Farley, M.D.	Sylvan S. Lewis & Son INC	3319 Olympia Ave

VS 1S0-REV. 1/1/65

W-436 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.
M.E. CASE NO. 65 5390

Registered No. 65 5390

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): WALTERHOEFER, DOROTHY

2. DATE AND HOUR OF DEATH: May 20, 1965 | 3:55 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): St. Joseph Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore Dundalk 21222
D. STREET ADDRESS (If rural, give location): 7 Mavista Avenue -

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Married	12-24-10	54				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Scheper	Wilhelmina Rieselman

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	219-12-7302	Husband, Mr. Leroy Walterhoefer, # 4,a,b,c,d.	

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 434.4 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cor Pulmonale

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from May 17, 1965 to May 20, 1965, that (I) (we) last saw the deceased alive on May 20, 1965 and that in(my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
S. Viriyapongse M.D.	Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒	May 20, 1965

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Sukhe Viriyapongse M.D.	1400 N. Caroline Street - 21213

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	May 24-1965	Lorraine Park	Dogwood Road, Woodlawn, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 21 1965	Robert E. Fahey M.D.	JOHN J. DUDA	7922 Wise Ave. Dundalk, Md. 22

VS 150-REV. 1/1/65

SAB 43-51-65 1

F-460

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5391 Registered No. 65 5391

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Ernest Fowler

2. DATE AND HOUR OF DEATH: 5-19-1965 | 6:15 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 24-04

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1521 Light Street 21230

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Divorced	12-5-1923	41				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic	Locke Ins. Co.	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Ernest A. Fowler	Frances Gibson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yess	W W # 2		Records: BCH-4940 Eastern Avenue	21224

MEDICAL CERTIFICATION

18. 581.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
(A) Septicemia	3 days
DUE TO (B) Renal Failure	3 days
DUE TO (C) Laennec's Cirrhosis	1 year

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from 5-5- 19 65 to 5-19- 19 65, that (I) (we) last saw the deceased alive on 5-19- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
C C J Carpenter					5-19-1965

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
C C J Carpenter		4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
B	5/22/65	Glen Haven	Baltimore

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 21 1965	Robert E. Farley, M.D.	McCully - 130 E. Fort Avenue	

VS 150-REV. 1/1/65

K-640 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5392 Registered No. 65 5392

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): MARGARET KARL

2. DATE AND HOUR OF DEATH: MAY 17, 1965 | 5:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): 115 N. LINWOOD AVE.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 6-61
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 115 N. LINWOOD AVE.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W.	Widowed	Sept. 1, 1873	91		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife.		Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Schlee	Mary Gazman

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	219-01-0819	Margaret Travers	115 N. Linwood Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 260 X 1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not meon the mode of dying, e.g., heort foilure, osthenio, etc. It meons the diseose, injury or complicotion which coused deoth.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if ony, giving rise to the obove couse (A) stoting the UNDERLYING CONDITION lost.

		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO	ARTERIOSCLEROTIC C.V.D.'s	10 + yrs.
(B) DUE TO	DIABETES	20 yrs.
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or about home, form, foctory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Boltimore City, give exoct locotion)

21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify thot (I) (this hospitol) ottended the deceased from 9/3 19 57 to 5/17 19 65, thot (I) (we) lost sow the deceosed alive on 3/24 19 65 ond that in (my) (our) opinion deoth occurred on the dote ond hour ond from the couses stoted above. (I) (We) (did) (did not) view the body ofter death.

23A. SIGNATURE	M.D.	Attending Phys. ✓	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
Benjamin Hyslop					5/19/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
B. HIRSTEIN		121 S. HIGHLAND AVE BALTO. 24 Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/20/65	HOLY REDEEMER CEM.	BALTIMORE Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 21 1965	Robert E. Farley, M.D.	B. DABROWSKI	2918 E. BALTIMORE ST.

VS 150-REV. 1/1/65

B-30D 1

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 5393

M.E. CASE NO.

CERTIFICATE OF DEATH

Registered No. 65 5393

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Susie Redfern (Boyd)

2. DATE AND HOUR OF DEATH: May 18, 1965 — 3:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Bar-Wil-Bar Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 9-09
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1304 Holbrook St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	Negro	Widowed	May 12, 1904	61				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		N.C.	U.S.A.

13. FATHER'S NAME: Ned Redferen

14. MOTHER'S MAIDEN NAME: Carrie Lyne

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Jannie Blakley	1307 Holbrook St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic C.V.D.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
DUE TO (B)
DUE TO (C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-21- 1965 to 5-18- 1965, that (I) (we) last saw the deceased alive on 5-14- 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE				23B. DATE SIGNED
C.R. Campbell M.D.	Attending Phys. ☑	Med. Director ☐	Staff Phys. ☐	5-20-65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
C.R. Campbell M.D.	1618 W. North Ave. Baltimore Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/23/65	Church Cem.	Chesterfield, S.C.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 21 1965	Robert E. Farley, M.D.	George A. Kelas	1548 N. Calhoun St.

VS 150-REV. 1/1/65

43-46-39 IB 1

F-663

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5394 Registered No. 65 5394

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Ida Mae Earhardt

2. DATE AND HOUR OF DEATH: 5-20-65 | 2:20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland #21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 6-04
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 217 N. Castle Street - #21231

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Divorced	4-22-06	59				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOMEMAKER	HOME	Maryland	USA

13. FATHER'S NAME: Robert L. Smith

14. MOTHER'S MAIDEN NAME: Ida E. Crist

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.		RECORDS-BCH-4940 Eastern Avenue-#21224	

MEDICAL CERTIFICATION

18. 163X I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Squamous Cell Carcinoma, Lung — INTERVAL BETWEEN ONSET AND DEATH: 6 years

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Cor Pulmonale
Respiratory Insufficiency

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-29 19 65 to 5-20 19 65, that (I) (we) last saw the deceased alive on 5-20 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
C.C.J. Carpenter		☐	☐	X	5-20-65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Dr. C.C.J. Carpenter M.D.	4940 Eastern Avenue-Baltimore, Maryland-21224

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5-24-65	BALTIMORE CEM.	BALTO., MD.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 21 1965	Robert E. Faikeyman	Harold Miller	2334 Hoffman St.

VS 150-REV. 1/1/65

W-2001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5395 Registered No. 65 5395

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): MRS. MAE ELIZABETH WOSK

2. DATE AND HOUR OF DEATH: 5-16-65 | 9 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 6-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21224
D. STREET ADDRESS (If rural, give location): 236 NORTH PORT STREET

5. SEX	6. RACE	7. MARRIED, ~~NEVER MARRIED~~ ~~WIDOWED~~, ~~DIVORCED~~ (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	MARRIED	5-9-27	38		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
MEAT TRIMMER		MARYLAND	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
ANDREW ZAPF	MARGARET HINKLEMAN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT HUSBAND	ADDRESS
No.		MR. ALBERT J. WOSK.	SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenio, etc. It meons the disease, injury or complication which caused deoth.)

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Rt. Cerebral embolus	36 hours
DUE TO (B)	atrial Fibrillation +	2-3 years
DUE TO (C)	Mitral Stenosis	R. H

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if ony, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical exominer)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exoct locotion)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~saw hospital~~) attended the deceased from May 15 19 65 to May 16, 19 65, that (I) (~~saw~~) last saw the deceased olive on May 16 19 65 and thot in (my) (~~our~~) opinion death accurred on the date and haur and from the causes stoted obave. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Charles T. Fletcher M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED: May 16, 1965

23C. PHYSICIAN'S NAME (Type): DR CHARLES T FLETCHER M.D. 23D. ADDRESS: Union Memorial Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5-20-65	HOLY ROSARY CEM.	BALTO., MD.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 21 1965	Robert E. Farley M.D.	Harry Miller	2334 Jefferson St.

VS 150-REV. 1/1/65

1

M-635

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 5396 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No. 65 5396

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) HOBERT CLARENCE MARTIN	2. DATE AND HOUR PRONOUNCED DEAD May 18, 1965 10:30 a M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) Alcazar Hotel Room 619

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
male	white	Widowed	May 27, 1903	61				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Boiler Fireman	Hotel	Marion, Virginia	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Kitty Wolfe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	1925-1938	225-18-9695	Rodney Martin	Joppa, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Arteriosclerotic cardiovascular disease DUE TO ANTECENDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE R Breitenecker M.D.

EXAMINER'S NAME (Type) Rudiger Breitenecker

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 5-19-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	May 20, 1965	Glenhaven Cemetery	GlenBurnie, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 21 1965	Robert E. Farley M.D.	Howard K. McComas & Son	Abingdon, Md.

VS 151-REV. 1/1/65

H-5225 1

65 5397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO.

Registered No. 65 5397

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): HENSEN, FREDERICK H.

2. DATE AND HOUR OF DEATH: MAY 20, 1965 | 3 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 248 S. EAST AVE.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD. B. COUNTY: 26-10
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO.
D. STREET ADDRESS (If rural, give location): 248 S. EAST AVE.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	WHITE	MARRIED	5/14/1891	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
AMERICAN CAN CO.		MD.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
HENRY HENSEN	CATHERINE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO —		MRS. MARY HENSEN	248 S. EAST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) CORONARY THROMBOSIS	UNKNOWN
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	DUE TO (B) ARTERIOSCLEROTIC CARDIO-VASC DISEASE	1 YEAR
	DUE TO (C) GENERALIZED ARTERIOSCLEROSIS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6/29 1951 to 5/20 1965, that (I) (we) last saw the deceased alive on 5/20 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☑	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
Henry J. Houska					5/21/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
HENRY J. HOUSKA		333 S. EAST AVE BALTO. 24 MD.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
BURIAL	5/24/65	OAKLAWN	BALTO. Co	MD.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 21 1965	Robert E. Farley M.D.	Geo. M. Hoffman	3218 HUDSON ST.

VS 180-REV. 1/1/65

K-6101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.
M.E. CASE NO. 65 5398

Registered No. 65 5398

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): ROBERT T. KIRBY JR.

2. DATE AND HOUR OF DEATH: 5-18-65 | 1:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Was DOA at S. Balto General Hosp at 1:45 Pm

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 24-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1445 Boyle St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	Married	5/8/18	47				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PATROLMAN
10B. KIND OF BUSINESS OR INDUSTRY: BALTO CITY P.D.
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Robert T. Kirby, Sr.
14. MOTHER'S MAIDEN NAME: Evelyn A. Howard

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): Yes W.W.II & Korean
16. SOCIAL SECURITY NO.: 218-10-2642
17. INFORMANT: Betty Kirby - 1445 Boyle St. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Adeno Carcinoma of Recto Sigmoid with local and
DUE TO
(B) Generalized Metastasis,
DUE TO
(C) Very Many to LIVER

INTERVAL BETWEEN ONSET AND DEATH: Ca with metastases was present in March 1964

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: Apr 1964 Dec 1964
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: above
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 1964 to Present 1965, that (I) (we) last saw the deceased alive on May 4 1964 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Leonard G Hamberry M.D.
M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 5-18-65
23C. PHYSICIAN'S NAME (Type): Leonard G. Hamberry M.D.
23D. ADDRESS: 323-25 Medical Arts Bldg Balto Md 21201

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/22/65	Oak Lawn Cemetery	Baltimore County, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 21 1965	Robert E. Farley M.D.	Robert C. Altenburg-6009 Harford Rd.

VS 150-REV. 1/1/65

B-635 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5399 Registered No. 65 5399

1. NAME OF DECEASED (Type or Print): BETTY (ELIZABETH) BREEDEN

2. DATE AND HOUR OF DEATH: 5-12-65. 11:10 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddiess or location): THE JOHNS HOPKINS HOSPITAL 33

4. USUAL RESIDENCE (Where deceosed lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 102
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rurol, give locotion): 33 W. PRESTON STREET

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In yeors lost birthday)	If Under 1 Yr. Months / Doys	If Under 24 Hrs. Hours / Min.
FEMALE	WHITE	WIDOW	1-7-07	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: EDGAR WADE

14. MOTHER'S MAIDEN NAME: MARGARET CAMPBELL

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give wor or dotes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

1B. 2367 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not meon the mode of dying, e.g., heart foilure, osthenio, etc. It meons the diseose, injury or complicotion which coused deoth.)

(A) DUE TO: Saddle Pulmonary embolism

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if ony, giving rise to the obove couse (A) stoting the UNDERLYING CONDITION lost.

(B) DUE TO: Postoperative duodenal cutaneous fistula 5 week

(C) Renal disease - Probable Chronic Pyelonephritis.

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: DIABETES MELLITUS.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2/5/65	Suspected Renal Tumor	YES	

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol examiner)	21B. PLACE OF INJURY (e.g., in or obout home, form, foctory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Boltimore City, give exoct locotion)

21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-31 1965 to 5-12- 19 65, that (I) (we) last saw the deceased alive on ____ 19____ and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
J. BRUCE IUPPA. M.D. M.D.	Attending Phys. ☐ Med. Director ☐ Staff*** Phys. ☐	

23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS
J. Bruce Iuppa M.D.		THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
		HOSPITAL DISPOSAL	

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 21 1965	Robert E. Faber, M.D.	HOSPITAL DISPOSAL	

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

SAB- 42-64-68

C-200

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5400 M.E. CASE NO.

Registered No. 65 5400

1. NAME OF DECEASED (Type or Print): Rita Cos

2. DATE AND HOUR OF DEATH: 5-20-1965 6:15 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: -03

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 516 South Montford Avenue 21224

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Single	8-18-1931	33		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Maryland	U.S.A.

13. FATHER'S NAME: John A. Cos

14. MOTHER'S MAIDEN NAME: Angelina Scopac

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Records: BCH	4940 Eastern Avenue 21224

MEDICAL CERTIFICATION

18. 753.1+1260X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Cardiac Arrest

DUE TO

(B) Anemia, Uremia

DUE TO

(C) Lawrence-Moon-Biedl Syndrome
Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

Years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from 1-19- 19 65 to 5-20- 19 65, that (I) (we) last saw the deceased alive on 5-20- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	23B. DATE SIGNED
C C J Carpenter	Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒	5-20-1965

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Dr. C C J Carpenter M.D.	4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-22-1965	Oak Lawn	Baltimore County, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 21 1965	Robert E. Farley M.D.	Lilly & Zeiler Inc. 1901 Eastern Ave,

VS 150-REV. 1/1/65

2-612 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5401 Registered No. 65 5401

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JARVIS, FORREST HERBERT

2. DATE AND HOUR OF DEATH: May 17, 1965 | 2 00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 5-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1505 N. Appleton St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	N	Widowed	10/24/86	78				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired def		Gloucester Co, Virginia	USA

13. FATHER'S NAME: James Jarvis

14. MOTHER'S MAIDEN NAME: Charlotte Patterson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	216-18-6362	Mrs Anna Pruitt	1565 N. Appleton St

CAUSE OF DEATH

1B. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not meon the mode of dying, e.g., heart failure, asthenia, etc. It means the diseose, injury or complicotion which coused death.)

(A) DUE TO: Septicemia — INTERVAL BETWEEN ONSET AND DEATH: 4 wks

(B) DUE TO: Prostatectomy

(C):

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		yes	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospitol) attended the deceased from April 13 1965 to May 17 1965, that (I) (we) last saw the deceased alive on May 17 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
Barry N. Rosenbaum		☐	☐	☑	May 17, 1965

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
BARRY N. ROSENBAUM		UNIVERSITY HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	5/21/65	Arbutus Memorial Park	Baltimore County	Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 21 1965	Robert E. Farber M.D.	Herbert E. Nutter	3035 W. North Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-4521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5402 Registered No. 65 5402

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) (MEDA ANN COLLINS) COLLINS, MEDA ANN

2. DATE AND HOUR OF DEATH 5-19-65 May. 19 1965 12:20A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location) ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY 25-43
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE ZONE 30
D. STREET ADDRESS (If rural, give location) 1956 HOLLINS FERRY ROAD

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	WHITE	MARRIED	3-14-96	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HSWIFE		MARYLAND	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JACOB BAKER	JANE ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no.	212-16-9668	ST. AGNES RECORDS-CATON & WILKENS AVES.	

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) ACUTE MYOCARDIAL INFARCTION 1 day
DUE TO
(B) Osteosclerotic carcinomatosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from MAY 18 1965 to MAY 19 1965, that (I) (we) last saw the deceased alive on MAY 19 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
F. D. D'Arcy					5/19/1965

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
F.D. D'ARCY		ST. AGNES HOSPITAL -

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	May. 22. 1965	Baltimore Cem.	Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 21 1965	Robert E. Fahey, M.D.	HENRY SANDER & SONS. INC. Baltimore Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-450 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5403 M.E. CASE NO.

Registered No. 65 5403

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): NOLAN, WILLIAM PURNELL

2. DATE AND HOUR OF DEATH: May 19, 1965 | 12:05 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
VETERANS ADMINISTRATION HOSPITAL
3900 LOCH RAVEN BLVD
BALTIMORE, MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 16-05
D. STREET ADDRESS (If rural, give location): 840 WHITMORE AVE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
MALE	NEGRO	Never Married	3-26-23	41				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
STOCK CLERK	UNKNOWN	MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
DELMOR, WILLIAMS	ANNABELLE, NOLAN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	3/13/43 to 12/13/43	214 14 0882	VETERANS HOSPITAL RECORDS	BALTIMORE, MARYLAND 21218

MEDICAL CERTIFICATION

18. 163X

	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	Far Advanced Epidermoid Carcinoma Rt. Upper Lobe Lung	10 months
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) DUE TO		
(B) DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from March 9, 1965 to May 19, 1965, that (I) (we) last saw the deceased alive on May 19, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
Anastacio Hoyumpa Jr.					5/19/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Anastacio Hoyumpa, Jr.		VETERANS HOSPITAL, BALTO., MD. 21218

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	5-24-65	Balto. Natl	Balto.	Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 21 1965	Robert E. Farley, M.D.	Morton + Dyer II	1701 Lawrence ST.

VS 150-REV. 1/1/65

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5404 Registered No. 65 5404

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): James Taylor

2. DATE AND HOUR OF DEATH: May 19, 1965 | 9:15 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): Provident Hospital, Inc.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY
1449 N. Parrish Street
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, Maryland
D. STREET ADDRESS (If rural, give location): 15-01

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	Negro	Married	1-30-05	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unemployed	NONE	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JAMES TAYLOR	MARTHA BANKS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		E. Taylor	1449 Parrish St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Myocardial Infarction

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO: Coronary Thrombosis

(C): Coronary Arteria-Atherosclerosis

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Congestive Heart Failure

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 19, 1965 to May 19, 1965, that (I) (we) last saw the deceased alive on May 19, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
Robert C. Blackmon M.D.	Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒	5/19/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Robert C. Blackmon M.D.	Provident Hospital, Inc.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5-23-65	CARVER MEM	LAUREL Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 21 1965	Robert E. Faulkner	MORTON + DYETT	1701 LAURENS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-152 1

BIRTH NO. 65 5405

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5405

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Carl C. Covington

2. DATE AND HOUR OF DEATH: 5-20-65 11:30 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 2828 W. Lanvale St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 16-06
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2828 W. Lanvale St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
male	Negro	Married	5-7-1898	67				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Tatum, S. C.	U.S.A.

13. FATHER'S NAME: Nathaniel Covington

14. MOTHER'S MAIDEN NAME: Sarah Covington

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-07-2882

17. INFORMANT: L. Covington ADDRESS: 2828 W. Lanvale St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

163X I

(A) DUE TO: Carcinoma of Lung

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO:

(C)

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from MARCH 19 65 to MAY 17 19 65, that ~~(I)~~ (we) last saw the deceased alive on MAY 17 19 65 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ~~(did)~~ (did not) view the body after death.

23A. SIGNATURE: Mustafa Onal M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 5/21/1965

23C. PHYSICIAN'S NAME (Type): Mustafa Onal, M.D. M.D.

23D. ADDRESS: University Hospital, Baltimore, Maryland 21201

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-24-65	MT. CALVARY	A.A. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 21 1965	Robert E. Faber, M.D.	Morton + Dyett	1701 Laurens St.

VS 150-REV. 1/1/65

V-525 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5406 Registered No. 65 5406

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): JOHNSON, HARRY, RICHARD

2. DATE AND HOUR OF DEATH: May 19, 65, 9.15 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): HOSPITAL FOR THE WOMEN OF MARYLAND.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND. B. COUNTY: 21218
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 9-01
D. STREET ADDRESS (If rural, give location): 705 CATOR Avenue.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	WHITE	WIDOWED.	11-24-1892	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED - MACH.	AUTO - PROP.	NEW JERSEY	U.S.A.

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES MEXICAN BORDER	215-10-9039	MRS. MURIEL G. HENDERSON	1303 CEDAR CROFT

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Broncho Pneumonia

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		partial	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from MAY 12 19 65 to MAY 19 19 65. that (I) (we) last saw the deceased alive on MAY 19 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ — 23B. DATE SIGNED: MAY 19 65

23C. PHYSICIAN'S NAME (Type): A. MENDOZA M.D. — 23D. ADDRESS: HOSPITAL FOR THE WOMEN OF MARYLAND.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/22/1965	Woodlawn	Woodlawn, Balto.Co., Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 21 1965	Robert E. Farley, M.D.	H.W.Jenkins & Sons Co.	4905 York Rd. Balto.12, Md.

VS 150-REV. 1/1/65

1

M-300

65 5407

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65 5407 Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): RUTH M. MUTH

2. DATE AND HOUR PRONOUNCED DEAD: May 20, 1965 | 9:00 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 308 Northfield Place

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-14
D. STREET ADDRESS (If rural, give location): 308 Northfield Place

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Married	Dec. 27, 1914	50				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Brooklyn, N. Y.	U.S.A.

13. FATHER'S NAME: Richard Mommers

14. MOTHER'S MAIDEN NAME: Grace Wallace

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Leo C. Muth	(Same)

MEDICAL CERTIFICATION

E916.0 + 3220

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Extensive Body Burns and Carbon Monoxide Intoxication.

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Acute Ethylism.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Home	308 Northfield Place 27-14

21D. TIME OF INJURY (APPROX.) (Month)	(Day)	(Year)	(Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
5	20	'65	A m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Fire in bedroom of home.

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] +Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 5/20/65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/22/1965	New Cathedral Cem.	Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 21 1965 Robert E. Farley M.D.		H.W.Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md.

VS 151-REV. 1/1/65

N 948.2

C-636 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5408 Registered No. 65 5408

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Collins M. Crowther
2. DATE AND HOUR OF DEATH: 5-19-65 12:30 A.M.
3. PLACE OF DEATH IN ALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) — A. STATE: Maryland B. COUNTY: AA — C. CITY OR TOWN (If outside city limits, write RURAL and give township): Gibson Island 52-00 — D. STREET ADDRESS (If rural, give location):
5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 7-11-09
9. AGE (In years last birthday): 55 — If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Executive
10B. KIND OF BUSINESS OR INDUSTRY: Plastic
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: Walter S. Crowther
14. MOTHER'S MAIDEN NAME: IRMA McGRAW
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 217-05-7081
17. INFORMANT: Mary V. Crowther — ADDRESS: Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchogenic carcinoma Rt. main bronchus — Months

(B) Bronchopneumonia due to confluent, bilateral — days

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED — While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-10 19 65 to 5-19 19 65, that (I) (we) last saw the deceased alive on 5-19 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Rodney L. Brimhall M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 5-19-65
23C. PHYSICIAN'S NAME (Type): RODNEY L. BRIMHALL M.D.
23D. ADDRESS: Union Memorial Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 5-21-65
24C. NAME of CEMETERY or CREMATORY: Sherwood
24D. LOCATION (City, town, or county) (State): Cockeysville Md.

25A. DATE REC'D BY HEALTH DEPT.: MAY 21 1965
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR — ADDRESS: H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md.

VS 150-REV. 1/1/65

C-62 1

1

BIRTH NO. 65 5409

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5409

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Chrispens Jr. William Henry SR.

2. DATE AND HOUR OF DEATH: 5/16/65 | 955 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): North Charles General Hosp. 2734 North Charles St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: F-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2544 Fleet St

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 2/27/1898
9. AGE (In years last birthday): 67
If Under 1 Yr. Months: Days | If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FIREMAN RET.
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MD
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: DAVID CHRISPENS
14. MOTHER'S MAIDEN NAME: Louise ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: 218-14-1317
17. INFORMANT: Patients Chart
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

I
(A) Congestive Heart failure. — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Arteriosclerotic Cardio.
DUE TO
(C) Vascular Disease.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/14/65 1965 to 5/16/65 1965, that (I) (we) last saw the deceased alive on 5/16/65, at 9.55 P.m. 1965, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Anselmo M. Alligood M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 5/16/65
23C. PHYSICIAN'S NAME (Type): ANSELMO M. ALLIGOOD M.D.
23D. ADDRESS: North Charles Gen. Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 5/20/65
24C. NAME of CEMETERY or CREMATORY: OAKLAWN CEMETERY
24D. LOCATION (City, town, or county) (State): BALTIMORE CO. MD.

25A. DATE REC'D BY HEALTH DEPT.: MAY 21 1965
25B. NAME OF REGISTRAR: Robert E. Faber, M.D.
25C. FUNERAL DIRECTOR: RAYMOND L. KACZOROWSKI
ADDRESS: 2525 FLEET ST.

VS 150-REV. 1/1/65

K-560 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5410 Registered No. 65 5410

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): KNORR, MARY E.

2. DATE AND HOUR OF DEATH: MAY 20, 1965 | 7:40A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): ST. AGNES HOSPITAL

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 20-08
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 4203 CONNECTICUT AVE. #29

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
FEMALE	WHITE	WIDOWED	8-20-91	73				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE	NONE	MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
GEORGE ROSENDALE	THERESA BRENDER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NONE		ST. AGNES HOSPITAL RECORDS; CATON &	WILKENS AVES.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 053 1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Staphylococcal septicemia — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO:

(C):

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Cerebro vascular accident

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from MAY 18 19 65 to MAY 20 19 65, that (I) (we) last saw the deceased alive on MAY 20 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE				23B. DATE SIGNED
William Allen Dear Jr. M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☑	5-20-65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
WILLIAM A. DEAR M.D.	ST. AGNES HOSPITAL; CATON & WILKENS AVES.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-24-65	New Cathedral	Baltimore, Maryland

25A. DATE RECD BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 21 1965	Robert E. Fowler	Howard H. Hubbard-4107 Wilkens Ave-21229

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-655 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5411 — Registered No. 65 5411

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): ROBERT L. DeeArmond
2. DATE AND HOUR OF DEATH: 5/20/65 — 3:50 A.M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): FRANKLIN SQUARE
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) — A. STATE: MD — B. COUNTY: 20-05 — C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE — D. STREET ADDRESS (If rural, give location): 535 S. CATHERINE ST
5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M
8. DATE OF BIRTH: 4/13/02
9. AGE (In years last birthday): 63 — If Under 1 Yr. Months / Days — If Under 24 Hrs. Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): UNEMPLOYED
10B. KIND OF BUSINESS OR INDUSTRY: CAR SALESMAN
11. BIRTHPLACE (State or foreign country): OHIO
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: CORA PARR
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes — (If yes, give war or dates of service): WWI
16. SOCIAL SECURITY NO.: 302-07-7669
17. INFORMANT: Mrs. Marie DeeArmond — ADDRESS: 535 S. Catherine St-23

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary edema

DUE TO

(B) Congestive Heart Failure

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED — While At Work ☐ — Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from MAY 19 1965 to MAY 20 1965, that (I) (we) last saw the deceased alive on MAY 20 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: P E Brion — M.D. — Attending Phys. ☐ — Med. Director ☐ — Staff Phys. ☑
23B. DATE SIGNED: 5/20/65
23C. PHYSICIAN'S NAME (Type): P E BRION — M.D.
23D. ADDRESS: FSH

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 5-24-65
24C. NAME of CEMETERY or CREMATORY: Lorraine Park Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: MAY 21 1965
25B. NAME OF REGISTRAR: Robert E. Faber M.D.
25C. FUNERAL DIRECTOR — ADDRESS: Howard H. Hubbard-4107 Wilkens Ave-21229

VS 150-REV. 1/1/65

C-145 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

BIRTH NO. 65 5412 Registered No. 65 5412

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Rebecca Kaplan

2. DATE AND HOUR OF DEATH: 5/19/65 | 1.05 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: BALTIMORE CITY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rurol, give locotion): 2013 Derrickson Rd.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In yeors lost birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
FEMALE	WHITE	WIDOWED	6/12/99	65				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	AT HOME	Baltimore, Maryland	United States

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
ISAAC BERMAN	LENA WAGGENHEIM

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	214-40-0558	Belle Palmisano	2013 Derrickson Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which coused death.)

(A) DUE TO: Gram Negative Sepsis — INTERVAL BETWEEN ONSET AND DEATH: 60 hrs possible

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO:

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Rheumatoid Arthritis, ASCVD

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED White At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospitol) attended the deceased from 5/18 1965 to 5/19 1965, that ~~(I)~~ (we) lost saw the deceased alive on 5/18 1965 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) (did ~~not~~) view the body after death.

23A. SIGNATURE	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
Melvin J. Kordon M.D.	☐	☐	☒	5/19/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
MELVIN J. KORDON M.D.	Sinai Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/21/65	BETH TFILOH	BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 21 1965	R. E. Farley, M.D.	Sol Levinson + Bros Inc	6010 Reisters Town Rd.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M24.2 1

65 5413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5413

BIRTH NO.

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print)	ROSE MICHAELSON
2. DATE AND HOUR OF DEATH	MAY 18, 1965 — 11:35 A M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location)	TEMPLE GARDEN APARTMENTS APT 2601 MADISON AVENUE 205 A
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	MARYLAND
B. COUNTY	3-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township)	BALTIMORE
D. STREET ADDRESS (If rural, give location)	2601 MADISON AVENUE APT 205A
5. SEX	FEMALE
6. RACE	WHITE
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	WIDOWED
8. DATE OF BIRTH	2/25/1908
9. AGE (In years last birthday)	57
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY	AT HOME
11. BIRTHPLACE (State or foreign country)	LYNCHBURG, VIRGINIA
12. CITIZEN OF WHAT COUNTRY?	USA
13. FATHER'S NAME	HARRY BROWNE
14. MOTHER'S MAIDEN NAME	DORA FOGEL
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	NO
16. SOCIAL SECURITY NO.	214-16-5845
17. INFORMANT / ADDRESS	MRS. DORIS LEE DOWNING 6656 MARROTT DRIVE

MEDICAL CERTIFICATION

18. I 420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) 1 Acute Coronary Thrombosis
DUE TO 2 Hypertensive C.V.D. — 3 years
(B) 3 Coronary insuff — 2 yrs
DUE TO 4 Congestive Heart Failure — 1 year.
(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Last Seen July 31 19 64 to May 18 19 65, that (I) (we) last saw the deceased alive on April 12 19 65, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. (sudden death 11.35 A M)

23A. SIGNATURE	M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐	23B. DATE SIGNED
Bernard J Cohen		5-19-65
23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
DR. BERNARD COHEN		MARYLANDER APARTMENTS

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
BURIAL	5/20/65	OHEB SHALOM	BALTIMORE	MARYLAND

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 21 1965	Robert E. Farley M.D.	SOL LEVINSON & BROS. INC.	6010 REISTERSTOWN RD

VS 150-REV. 1/1/65

C-160 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5415 Registered No. 65 5415

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): DOROTHY V. COFER

2. DATE AND HOUR OF DEATH: 5/18/65 | 430 a.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: — 20-05
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 316 S. Smallwood St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	Couc.	Separated	9/9/27	37		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	Maryland	U.S.A.

13. FATHER'S NAME: Oscar M. Young

14. MOTHER'S MAIDEN NAME: Grace Emmart

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No —	220-22-5706	Chart.	

MEDICAL CERTIFICATION

18. I 170X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO: Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 2 mos.

(B) DUE TO: Carcinoma right breast — 7 mos.

(C) —

II DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NDT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Oct, 1964	Carcinoma (R) breast	No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?
—		—

22. I certify that (I) (this hospital) attended the deceased from 4/14/1965 to 5/18/1965, that (I) (we) last saw the deceased alive on 5/17/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
Carl F. Berner					5/18/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
CARL F BERNER		University Hosp.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5-21-65	LOUDON PARK	BALTIMORE, MD.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Farley, M.D.	Fred A. Cole	1913 W. Balto. St.

VS 150-REV. 1/1/65

Z-3451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5414 Registered No. 65 5414

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): DOROTHY ZETLIN

2. DATE AND HOUR OF DEATH: MAY 19, 1965 | 3 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 4003 FORDLEIGH ROAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 27-20
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 4003 FORDLEIGH ROAD

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
FEMALE	WHITE	DIVORCED		68				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SOCIAL WORKER		RALSTON, PENNSYLVANIA	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
BENJAMIN ENGEL	FANNIE GOLDBERG

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	218-30-6137	MRS. FANNIE ENGEL	4003 FORDLEIGH ROAD

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: Carcinoma of Colon — 8 months

(B) DUE TO:

(C):

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
8 Nov 1964	Carcinoma Colon	NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	White At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from 1932 19 ____ to 5-19-65 19 ____, that (I) (we) last saw the deceased alive on 5/19/65 19 ____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE	M.D.	23B. DATE SIGNED
Milton Kirsch	Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐	5/20/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
DR. MILTON KIRSCH M.D.	4000 NORTHERN PARKWAY

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/21/65	AITZ CHAIM	BALTIMORE MARYLAND

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 21 1965	Robert E. Farley M.D.	SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

P-362

BIRTH NO. 65 5416

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. X 65 5416

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) CHRISTOPHINE PATTERSON	2. DATE AND HOUR PRONOUNCED DEAD May 20, 1965 3:50 a M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) City Hospital	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balto C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 53-00 D. STREET ADDRESS (If rural, give location) 154 Carver Road

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
female	colored	married	Feb. 8, 1911	54				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
clerk		Zuni, Virginia	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Albert Green	Rebecca Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	214-26-6491	Cornelius Patterson	154 Carver Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

I 331X-I 581.1

(A) Intracranial hemorrhage

DUE TO

ANTECENDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hepatic Disease (Chronic Alcoholism)

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☒ Inspection ☐ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) Rudiger Breitenecker M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 5-22-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	May 22, 1965	Arbutus Memorial	Arbutus, Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 24 1965	Robert E. Farley M.D.	Morton and Dyett Funeral Home, Inc.

VS 151-REV. 1/1/65

C-636 1

33 35 84 RS
CARTER, IRENE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5417 Registered No. 65 5417

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): IRENE CARTER

2. DATE AND HOUR OF DEATH: 5-20-65 | 9 40 pm. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 20-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1826 W. BALTIMORE ST.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	NEGRO	WIDOW	8-23-98	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOMEMAKER	At Home	Odenton - MD	U.S.A.

13. FATHER'S NAME: JOHN SMITH

14. MOTHER'S MAIDEN NAME: ~~RICHARD~~ CLARA ~~CORA~~ SMITH

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		KENNETH CARTER	1826 W BALTIMORE ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
I (A) DUE TO	Uremia	1 week
(B) DUE TO	Ruptured Steel Wilson's Disease	5 yrs
(C)	Diabetes Mellitus	15 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-1 19 65 to 5-20 19 65, that (I) (we) last saw the deceased alive on 5-20 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ~~(did)~~ (did not) view the body after death.

23A. SIGNATURE: Bruce Lee Evatt M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED: 5-20-65

23C. PHYSICIAN'S NAME (Type): BRUCE LEE EVATT M.D. 23D. ADDRESS: JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/25/65	Baltimore	Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Farkas M.D.	Mauzy & Hayes	1508 Gilmor St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-150 1

BIRTH NO. 65 5418

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. X 65 5418

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): REHREIN ELEANOR

2. DATE AND HOUR OF DEATH: 5/21/65 | 8.10 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): MARYLAND GENERAL HOSPITAL 827 LINDEN AVE BALTO 1, MD.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): OWINGS MILLS 21117
D. STREET ADDRESS (If rural, give location): 6 STRAWHAT Rd. Apt. 2B

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	MARRIED	3-9-87	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE	HOUSEWIFE	MARYLAND	U.S.A

13. FATHER'S NAME: EDWARD GRAEFE

14. MOTHER'S MAIDEN NAME: /

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		MARYLAND GEN. HOSP.	827 LINDEN AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) DIABETES	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	DUE TO (B) PNEUMONIA.	
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/25 19 65 to 5/21 19 65, that (I) (we) last saw the deceased alive on 5/21 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
Pietro Lastrucci					5/21/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
LASTRUCCI PIETRO		MARYLAND GENERAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
BURIAL	5-25-65	LOUDON PARK CEM	BALTO	MARYLAND

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 24 1965	Robert E. Faulkner, M.D.	WEBER FUNERAL HOME 5311 EDMONDSON AVE

VS 150-REV. 1/1/65

1

5-530

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 65 5419 Registered No. 65 5419

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BENNETT SMITH

2. DATE AND HOUR PRONOUNCED DEAD: 5-17-65 1:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): PROVIDENT HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-03
D. STREET ADDRESS (If rural, give location): 2400 Francis Street

39/59

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Colored		10 JUNE 1894	68				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FISHERMAN	COMMERCIAL FISHERIES	VIRGINIA	

13. FATHER'S NAME: JOHN R. SMITH

14. MOTHER'S MAIDEN NAME: IRENE L. BEE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 216-12-0137

17. INFORMANT: MR. WILLIAM SMITH ADDRESS: 823 HARLEM AVE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
422.1
(A) Arteriosclerotic cardiovascular disease
DUE TO
(B)
DUE TO
(C)

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: R. S. Fisher M.D.

EXAMINER'S NAME (Type): RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 5-17-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
BURIAL	21 MAY 1965	BALTO. NAT'L.	BALTO. MD.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 24 1965 Robert E. Farley M.D.		HOLLAND FUNERAL HOME 1631 DRUID HILL AVE.

VS 151-REV. 1/1/65

B-612 1

BIRTH NO. 65 5420

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5420

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOHN W. BARBAKOS

2. DATE AND HOUR PRONOUNCED DEAD: 5/21/65 8:35 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION: City Hospitals
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 601 Seena Rd. Balto. 21

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
male	white	Never married	10/10/43	21				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Revere - Copper & Brass		Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Louis Barbakos	Ella Lyons

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	1960-		Parents	(Same as above)

MEDICAL CERTIFICATION

E 821.4

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Extensive multiple injuries
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		yes	yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	street	Eastern Ave. 5300

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
5 21 65 8:15a.m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	driver of motorcycle which jumped concrete divider in street

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
ASSOCIATE MEDICAL EXAMINER [X]

DATE SIGNED: 5/21/65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/24/65	Oak Lawn	Balto. Co. Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Farber M.D.	Connelly	300 Mace Ave. Balto. 21

VS 151-REV. 1/1/65 N 869.2

470 ft west of Ashley Rd

S-530 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

BIRTH NO. 6515072 65 5421 Registered No. 65 5421

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Schmidt, Boy Baby ~~III~~ Wm. Edgar

2. DATE AND HOUR OF DEATH: 5/20/65 | 8:25 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location): Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Brooklyn
D. STREET ADDRESS (If rural, give location): 4933 Brookwood Rd

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	S	5-16-65		4	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Balto. Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Wm. E. Schmidt II	Lilly Hamlet

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	None	Family	same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracranial Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 100 Hours

DUE TO

(B) Prematurity

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-16 1965 to 5/20 1965, that (I) (we) last saw the deceased alive on 5/20 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: W. Standiford M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ — 23B. DATE SIGNED: 5/20/65

23C. PHYSICIAN'S NAME (Type): Willard E. Standiford M.D. — 23D. ADDRESS: Mercy Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-21-65	Glen Haven	Glen Burnie, A.A. Co. Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Farley M.D.	McCully	237 Patapsco Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-365 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5422 Registered No. 65 5422

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): STERN, ARTHUR

2. DATE AND HOUR OF DEATH: 17 May 65 | 12 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University 38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY Frederick
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Braddock Heights, Md.
D. STREET ADDRESS (If rural, give location) 60-00

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	widowed	12-16-89	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
salesman (retired)		Md.	US.

13. FATHER'S NAME: Solomon Stern

14. MOTHER'S MAIDEN NAME: Jennie Rosenoun

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes W.W. I	212-09-3611	Mr. Arthur R. Stern	Braddock Heights, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Esophageal cancer

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

DUE TO (B) Hepatic decompensation

(C) Cirrhosis

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. myocardial ischemia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
4-20-65	portal hypertension	yes	no

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 24 19 65 to May 17 19 65, that (I) (we) last saw the deceased alive on May 17 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☒	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
Richard P. Norgaard					17 May 65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
RICHARD P. NORGAARD		University Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-20-1965	Mount Olivet Cemetery	Frederick, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Farley, M.D.	Robert E. Dailey & Son	Frederick, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

43-61-16 AM 1

S-530

BIRTH NO. 65 5423

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 5423

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): ANNA ~~Hannah~~ Smith

2. DATE AND HOUR OF DEATH: 5-20-65 | 8:30 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 3-18
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4979 Edgemere Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Widowed	5-20-~~87~~ 78	87 ~~78~~				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	—	Maryland	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
UNK	UNK

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
—	218-05-7930B	RECORDS: B.C.H.	4940 Eastern Avenue #21224

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
I	(A) Cerebral Vascular Accident of Brain Stem	15 Minutes
ANTECEDENT CAUSES: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	DUE TO (B) Arteriosclerotic Cardio Vascular Disease with Cerebral Insufficiency	? Years
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-16 19 65 to 5-20 1965, that (I) (we) last saw the deceased alive on 5-20- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
C. J. Carpenter M.D.	Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒	5-20-65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Dr. Charles Carpenter M.D.	4940 Eastern Avenue #21224

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5-22-65	BALTIMORE CEMETERY	BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Tarbert, M.D.	Paul E. Clement & Son	3665 Chestnut Ave

VS 150-REV. 1/1/65

1

A-435

BALTIMORE CITY HEALTH DEPARTMENT

X 65 5421

BIRTH NO. 65 5424

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MAURICE Franklyn ALTON, Jr.

2. DATE AND HOUR PRONOUNCED DEAD: June 8, 1965 11:40 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Johns Hopkins Hospital

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: A.A.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Annapolis
52-10
D. STREET ADDRESS (If rural, give location): Loretta Heights

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months / Days / Hours / Min.
Male	White	Married	Oct. 31, 1925	39	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic	Marine	Annapolis, Md.	USA

13. FATHER'S NAME: Maurice F. Alton, Sr.

14. MOTHER'S MAIDEN NAME: Prudence Lambright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
yes	WWII	216-18-5044	Catherine L. Alton-wife same as #4

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

E857X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Massive 2nd and 3d Degree Body Burns.

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B)

DUE TO (C)

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Yacht Yard	East Port, Md. 52-00

21D. TIME OF INJURY (APPROX.)	(Month)	(Day)	(Year)	(Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	5	27	'65	A m.	WHILE AT WORK [X] NOT WHILE AT WORK [ ]	Gasoline explosion aboard yacht.

22. I certify that I held an Inquiry [ ] Inspection [X] Autopsy [ ] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE Charles S. Petty M.D.

EXAMINER'S NAME (Type) Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED 6/9/65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	6/11/65	Hillcrest Mem. Cem.	Annapolis, Md.

24A. DATE RECD BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
JUN 14 1965	Robert E. Farbman	Hopping Funeral Home, Annapolis, Md.

VS 151-REV. 1/1/65

N 948.2

N-320 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5425 Registered No. 65 5425

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): LAURA ESTHER NATWICK
2. DATE AND HOUR OF DEATH: 5/21/65 12:35 P.M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND
   FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
   A. STATE: Md. B. COUNTY: Baltimore
   C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 63-00
   D. STREET ADDRESS (If rural, give location): 10316 Reisterstown Rd
5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH: 6/29/75
9. AGE (In years last birthday): 89
   If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Wisconsin
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: James Houston
14. MOTHER'S MAIDEN NAME: Lydia Lyon
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 220-14-2256
17. INFORMANT: Robert Henry Natwick Towson 21204 123 Edgewood Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
I (A)	Pulmonary embolus	hrs
DUE TO (B)	Pelvic vein thrombosis	days
DUE TO (C)	Carcinoma of rectum & cecum	
II	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): ✓
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/16 19 65 to 5/21 19 65, that (I) (we) last saw the deceased alive on 5/21 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Edward A Person M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 5/21/65
23C. PHYSICIAN'S NAME (Type): EDWARD A. PERSON M.D.
23D. ADDRESS:

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: May 24-1965
24C. NAME of CEMETERY or CREMATORY: Druid Ridge
24D. LOCATION (City, town, or county) (State): Baltimore Co. Maryland

25A. DATE REC'D BY HEALTH DEPT.: MAY 24 1965
25B. NAME OF REGISTRAR: Robert E. Tabery M.D.
25C. FUNERAL DIRECTOR: Burgee Funeral Home ADDRESS: 363 Falls Road
Mrs. A. Burgee

VS 150-REV. 1/1/65

M-254 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5426 Registered No. 65 5426

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): ANNA MARGARET MCCONNELL

2. DATE AND HOUR OF DEATH: 5 22 65 | 10:00 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location): ST AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 15-47
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 16
D. STREET ADDRESS (If rurol, give location): 3015 ELGIN AVENUE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	WHITE	WIDOWED	12 30 91	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE		MARYLAND	U.S.A.

13. FATHER'S NAME: Aloysius Kispert

14. MOTHER'S MAIDEN NAME: MARIE ZENZER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-10-3313

17. INFORMANT: BT AGNES HOSPITAL RECORDS ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Acute Myocardial Infarction

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO:

(C):

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5 14 1965 to 5 22 65, that (I) (we) last saw the deceased alive on 5 22 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED: 5/22/65.

23C. PHYSICIAN'S NAME (Type): RAFAEL H MARIN M.D. 23D. ADDRESS:

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/25/65	Cathedral Cemetery	Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 24 1965	Robert E. Faulkner	J Melville Jenkins 2713 Kirk Ave

VS 150-REV. 1/1/65

1

H-516

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

M.E. CASE NO. 65 5427

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5427

1. NAME OF DECEASED (Type or Print): GEORGE H. HUMPHRIES

2. DATE AND HOUR PRONOUNCED DEAD: May 19, 1965 | 11:30 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 1800 N. Calvert St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-05
D. STREET ADDRESS (If rural, give location): 1800 N. Calvert St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
male	white	Married	Feb. 11, 1912	53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Roofer		Virginia	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William I. Humphries	Dolly A. Bowen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW-11	223-12-2056	William A. Humphries	2608 N. 3rd. St. Arlington, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

I
(A) Cirrhosis of the liver
DUE TO

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Chronic ethylism
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type): Rudiger Breitenecker M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 5-19-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	May 21, 1965	Arlington National	Arlington, Virginia

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 24 1965	Robert E. Farber, MA	Ives Funeral Home, Inc. 2847 Wilson Blvd by: Burr E. Rogers, Jr. Arlington, Va.

VS 151-REV. 1/1/65

H-4001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5428 Registered No. 65 5428

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) HALEY, Iva Lee

2. DATE AND HOUR OF DEATH May 18, 1965 7:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

St. Joseph's Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Balto

C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21220

D. STREET ADDRESS (If rural, give location) 119 Selfridge Road

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Married	September 9, 1899	65				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Homemaker		Mississippi Missippi	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph M. Melden	Alice Anderson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs. Billy Childers	46 Henderson Road

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I71X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) DUE TO Distant Metastasis of cervical cancer	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 9 19 65 to May 18 19 65, that (I) (we) last saw the deceased alive on May 18 19 65 and that In(my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
Donghae Lee M.D.	Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒	May 18, 1965

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Donghae Lee M.D.	1400 North Caroline Street

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	May 19, 65	Roseland Park Cemetery	Hattiesburg, Mississippi

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Farley, M.D.	Wm. Cook-Brooks, Inc.	1217 St. Paul St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-620 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5429 Registered No. 65 5429

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): PEARLE L. BARRICK

2. DATE AND HOUR OF DEATH: 5/17/65 2:15 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location): UNIVERSITY OF MARYLAND HOSP. BALTIMORE MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: Garrett
C. CITY OR TOWN (If outside city limits, write RURAL and give township): KITZMILLER
D. STREET ADDRESS (If rurol, give location):

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
female	WHITE	WIDOWED	11/11/1903	61				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
TEACHER	Public School	MARYLAND	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
DAVID SHARPLESS	MARY STEWART

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		CHART	

MEDICAL CERTIFICATION

18. 237X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO: Cerebellopontine angle tumor ~~Respiratory Arrest~~ — INTERVAL BETWEEN ONSET AND DEATH: UNKNOWN ~~4 DAYS~~

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if ony, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO:

(C):

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Respiratory Arrest

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
5/13/65	Resection of Brain tumor	No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospitol) attended the deceased from 4/29/65 19 to 5/17/65 19, that (I) (we) last saw the deceased alive on 5/17/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
Brandon L W Adams		☐	☐	☐	5/17/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
BRANDON L. W. ADAMS		1365 Hilton Ave. Balto, 17, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	May 17, 1965	Mt. Zion Cemetery	R.D. Swanton, Garrett Co., Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Farley, M.D.	Wm. Cook-Brooks, Inc.	1217 St. Paul Street

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-630 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5430 Registered No. 65 5430

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Carmino Trotta

2. DATE AND HOUR OF DEATH: May 19 1965 | 6:10 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Balt
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 3700
D. STREET ADDRESS (If rural, give location): 2506 Putty Hill Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Cauc.	Widowed	11-6-87	77				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rail Road worker	Retired	Italy	United States

13. FATHER'S NAME: unknown - Michael Trotta

14. MOTHER'S MAIDEN NAME: unknown - Serafina Stable

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
unknown	-	717-07-6307	Patient's chart History	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO	Rt. lower lobe pneumonia	2 wks
(B) DUE TO	Chronic emphysema	10-15 yrs.
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Arteriosclerotic Cardiovascular Disease

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from May 7, 1965 to May 19 1965, that (I) (~~we~~) last saw the deceased alive on May 19 1965 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Charles T. Fletcher M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED: May 19 1965

23C. PHYSICIAN'S NAME (Type): CHARLES T. FLETCHER M.D. 23D. ADDRESS: Union Memorial Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/22/65	Sacred Heart of Jesus	German Hill Rd.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Farley M.D.	Joseph M. Zaniewski	263 S. Conkling St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-2631

BIRTH NO. 65 5431

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 5431

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): McCarthy, Sister Barbara (Josephine)

2. DATE AND HOUR OF DEATH: May 20, 1965 — 9:21 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Villa Saint Michael

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4000 Forest Hill Road 21207

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Single	Aug. 2, 1883	81				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
social work	children's institutions	San Francisco, Calif.	U.S.A.

13. FATHER'S NAME: Charles - San Francisco, Calif.

14. MOTHER'S MAIDEN NAME: Mary Ellen Gillespie - San Francisco, Calif.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	none	Sister Mary Louise, Superior	same as above

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) generalized arteriosclerosis ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		no	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 29, 1960 to May 20, 1965, that (I) (we) last saw the deceased alive on May 18, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☒	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
Damian P. Alagia					May 20, 1965

23C. PHYSICIAN'S NAME (Type): Damian P. Alagia M.D.

23D. ADDRESS: 3316 Frederick Ave.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/22/65	St. Joseph's	Emmitsburg, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Farber, M.D.	Stewart & Mowen Co.	108 W. North Av., City

VS 150-REV. 1/1/65

T-460 1

BIRTH NO. 65 5432

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 5432

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Nina J. Taylor
2. DATE AND HOUR OF DEATH: 5-20-65 | 12:30 A.M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND
   FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
   A. STATE: Md. B. COUNTY: 102
   C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto - 2
   D. STREET ADDRESS (If rural, give location): 808 St. Paul St.
5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Divorced
8. DATE OF BIRTH: 12-10-87
9. AGE (In years last birthday): 77
   If Under 1 Yr. Months: Days | If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Harford Co. Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: James L. Bowman
14. MOTHER'S MAIDEN NAME: Jennie Gorrell
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 212-28-0623
17. INFORMANT: Ralph L. Taylor
    ADDRESS: Route #2 Aberdeen, Md.

MEDICAL CERTIFICATION

18. 260 X I
    DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
    (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
    ANTECEDENT CAUSES
    DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH
(A) DUE TO: C.H.F. (Pulm. Edema)
(B) DUE TO: Diabetes Mellitus
(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 none
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): no
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/20 19 65 to 5/20 19 65, that (I) (we) last saw the deceased alive on 5/20 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: David M. Nichols Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 5/20/65
23C. PHYSICIAN'S NAME (Type): David M. Nichols Jr. M.D.
23D. ADDRESS: Baltimore, Maryland

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 5/23/65
24C. NAME of CEMETERY or CREMATORY: Rock Run Cemetery
24D. LOCATION (City, town, or county) (State): Havre de Grace, Maryland

25A. DATE REC'D BY HEALTH DEPT.: MAY 24 1965
25B. NAME OF REGISTRAR: Robert E. Farber M.D.
25C. FUNERAL DIRECTOR: Walter McConchie Sr.
Tarring Funeral Home, Aberdeen, Md.

VS 150-REV. 1/1/65

W-4221

BIRTH NO. 65 5433

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 5433

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): MARYANNA (MAMIE) WALCZUK

2. DATE AND HOUR OF DEATH: May 21, 1965 | 7.20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 4411 Frankford Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 26-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4411 Frankford Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Married	11/30/95	69				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	U.S.A.

13. FATHER'S NAME: Frank Jankiewicz

14. MOTHER'S MAIDEN NAME: Rozalia Pacyna

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
-	-	218-50-5558	Mr. Joseph Walczuk,	4411 Frankford Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Hypertensive Cardio-Vascular-Renal disease	5/9/65 to 5/21/65
ANTECEDENT CAUSES: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	DUE TO (B) Arteriosclerosis -	
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/9/65 19 to 5/21/65 19, that (I) (we) last saw the deceased alive on 5/21/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
Mitchell J. Kunkowski M.D.	Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐	5/24/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
MITCHELL KUNKOWSKI MD M.D.	2529 Eastern Ave

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, [illegible] (State)
Burial	5/25/65	St. Stanislaus	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 24 1965	Robert E. Farley M.D.	M.F. SADOWSKI & SONS, 1808 EASTERN AVE

VS 150-REV. 1/1/65

B-508 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5434 Registered No. 65 5434

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Mary E. Bien

2. DATE AND HOUR OF DEATH: 5-21-1965 | 4 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Harford Gardens Con. Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Harford
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Box 101A. Joppa Maryland

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Single	4-21-1879	86		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Nurse	Practical	Baltimore Md.	U.S.A.

13. FATHER'S NAME: John Bien

14. MOTHER'S MAIDEN NAME: Catherine Thoms

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	243-48-9328 None	Mrs Thielemenn Jerusalem Road Joppa, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease DUE TO

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

INTERVAL BETWEEN ONSET AND DEATH: (A) 10 yrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from May 1960 to May 21 1965, that (I) (~~we~~) last saw the deceased alive on May 21 1965 and that in (~~my~~) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
E. Allessi M.D.	Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐	5/21/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Dr E.J. Allessi M.D.	6217 Harford Road

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-24-1965	Parkwood Cemetery	Baltimore Co. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 24 1965	Robert E. Farley, M.D.	Lassahn Funeral Home 7401 Belair Road

VS 150-REV. 1/1/65

L-625 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5435 Registered No. 65 5435

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Adolph C. Luerssen

2. DATE AND HOUR OF DEATH: May 20, 1965 | 7:30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 4506 Schley Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 27-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4506 Schley Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	8-6-1894	70				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Minister	Lutheran Church	Baltimore Md.	U.S.A.

13. FATHER'S NAME: Charles Hl Luerssen

14. MOTHER'S MAIDEN NAME: Caroline Lieber

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		217-22-8485	Mrs Ida Luerssen	4506 Schley Avenue

MEDICAL CERTIFICATION

1B. 420.0 | 772

CAUSE OF DEATH — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not meon the mode of dying, e.g., heort foilure, osthenio, etc. It meons the diseose, injury or complicotion which coused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if ony, giving rise to the obove couse (A) stoting the UNDERLYING CONDITION lost.

		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO	Arteriosclerotic Heart Disease	
(B) DUE TO	Congestive failure	
(C)	Old Grand Mal Epilepsy (Status Epilepticus)	
	Gen Pastinodelerosis	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Carcinoma Prostate

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
—	—		

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from July 1 19 55 to May 20 19 65, that (I) (~~we~~) last saw the deceased alive on May 20 19 65 and that In(my) (~~our~~) opinion death occurred on the date and hour and from the couses stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
Donald W. Mintzer M.D.	Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐	May 21 1965

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
DONALD W. MINTZER M.D.	3009 EVERGREEN AVE BALTO MD 21214

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-24-1965	Immanuel Luth Cemetery	Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robt E. Farley, MD	Lerner Funeral Home	7401 Belair Road

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

43-46-72 AM 1

S-302

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 5436

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5436

1. NAME OF DECEASED (Type or Print): James Scott

2. DATE AND HOUR OF DEATH: 5-23-65 | 1:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1035 Orleans Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	Negro	Married	8-24-86	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Jamaica, West Indies	U. S. A.

13. FATHER'S NAME: UnKnown

14. MOTHER'S MAIDEN NAME: Lucy

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			RECORDS: B.C.H.	4940 Eastern Avenue #21224

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. I 22 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Metastatic Carcinoma Prostate	3 Years
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	DUE TO (B)	
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Gram Negative Septicemia	3 Days

MEDICAL CERTIFICATION

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-29 19 65 to 5-23- 19 65, that (I) (we) last saw the deceased alive on 5-23- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
C.J. Carpenter					5-23-65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Dr. Charles Carpenter		4940 Eastern Avenue #21224

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/26/65	Mt. Calvary Cemetery	Ann Arundel Cty. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robt E. Faber, M.D.	A. Halstead	1206 W. North Ave.

VS 150-REV. 1/1/65

W-623 1

$600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5437 Registered No. 65 5437

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ROSIE WRIGHT (Gone)

2. DATE AND HOUR OF DEATH: 5/17/65 9:40 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): FRANKLIN SQ. HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: 8-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 897 W. FAYETTE

36

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	N	SEPARATED	12/3/15	49				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		NC	USA

13. FATHER'S NAME: JOHN STRICKLING

14. MOTHER'S MAIDEN NAME: ALPHIA CLARK

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Hospital Chart	

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 490X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: RT MIDDLE LOBE LOBAR PNEUMONIA

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO:

(C):

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/17/65 19 65 to 19, that (I) (we) last saw the deceased alive on 5/17/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: P E Brion M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 5/17/65

23C. PHYSICIAN'S NAME (Type): P. E. BRION M.D.

23D. ADDRESS: Franklin Sq. Hosp

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/24/65	Mt. Calvry Cemetry	A A County Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Farley M.D.	A Hatfield	9780 mdHdale

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 651/2252 65 5438 M.E. CASE NO. Registered No. 65 5438

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): BRISBON, ANTHONY JOSEPH
2. DATE AND HOUR OF DEATH: May 21, 1965 1:50 A. M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND
   FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): St. Joseph Hospital
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
   A. STATE: Md. B. COUNTY: 19-04
   C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 23
   D. STREET ADDRESS (If rural, give location): 1825 Eagle Street
5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: 5/19/65
9. AGE (In years last birthday): If Under 1 Yr. Months: Days: 2 If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Edith Williams
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give wor or dotes of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Chart ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

762.5 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not meon the mode of dying, e.g., heort foilure, osthenio, etc. It meons the diseose, injury or complicotion which coused death.)

(A) Prematurity

DUE TO

(B) Anoxia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if ony, giving rise to the above couse (A) sloting the UNDERLYING CONDITION lost.

(C) Pulmonary Atelectasis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)
21B. PLACE OF INJURY (e.g., in or about home, form, foctory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Boltimore City, give exoct locotion)
21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify thot (I) (this hospitol) ottended the deceased from 5/19/65 19 to 5/21/65 19, thot (I) (we) lost saw the deceased alive on 5/21/65 19 ond thot in(my) (our) opinion death occurred on the date and hour ond from the couses stoted above. (I) (We) (did) (did not) view the body after deoth.

23A. SIGNATURE: Glocrito G Sagisi M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 5/21/65
23C. PHYSICIAN'S NAME (Type): Glocrito G. Sagisi M.D.
23D. ADDRESS: 1400 N. Caroline Street, 21213

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 5/24/65
24C. NAME of CEMETERY or CREMATORY: Mt Calvary Cemetry
24D. LOCATION (City, town, or county) (State): A A County Md

25A. DATE REC'D BY HEALTH DEPT.: MAY 24 1965
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Adolphus Halstead ADDRESS: 918 Druid Hill Ave

VS 150-REV. 1/1/65

39-85-15 AM

5-160

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined couse; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician wos in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains ore embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.
M.E. CASE NO. 65 5439

Registered No. 65 5439

1. NAME OF DECEASED (Type or Print): Eddie Suber

2. DATE AND HOUR OF DEATH: 5-20-65 | 7:00 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore (Balto)
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Rural
D. STREET ADDRESS (If rural, give location): 22 Cottage Avenue #21222

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Negro	Separated	7-10-04	60				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		South Carolina	U. S. A.

13. FATHER'S NAME: Beryle Suber

14. MOTHER'S MAIDEN NAME: Mary

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
				RECORDS: B.C.H. 4940 Eastern Avenue #21224

MEDICAL CERTIFICATION

18. 296X I — CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does nat meon the mode of dying, e.g., heart failure, asthenia, etc. It means the diseose, injury or complicatian which coused death.)

(A) Respiratory Failure
DUE TO
(B) Thrombotic Thrombocytopenic Purpura

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above couse (A) stating the UNDERLYING CONDITION last.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from 4-30 19 65 to 5-20- 19 65, that (I) (we) last saw the deceased alive on 5-20- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
C. J. Carpenter		☐	☐	☒	5-20-65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Dr. Charles Carpenter		4940 Eastern Avenue #21224

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/24/65	Mt Calvary Cemetry	A A County Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Farley, M.D.	Adolphus Halstead	918 Druid Hill Ave

VS 150-REV. 1/1/65

1

B-621

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 5440

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5440

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EDITH BRISBON (Brisbane)

2. DATE AND HOUR PRONOUNCED DEAD: May 19, 1965 10:25a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): St. Joseph Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-04
D. STREET ADDRESS (If rural, give location): 1825 Eagle St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
female	colored	Separated		35				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		S Carolina	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Hannahan Williams	Josephine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	212-40-2392	Mr Hannahan Williams	2300 Fayette St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

443 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease
DUE TO and bronchopneumonia

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 5-19-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/24/65	Mt Calvary Cemetry	A A County Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Farley, M.D.	Adolphus Halstead	918 Druid Hill Ave

VS 151-REV. 1/1/65

4-208 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5441 Registered No. 65 5441

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Pearl V. Joyce

2. DATE AND HOUR OF DEATH: May 21, 1965 6:30 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 100 North Paca Street, Century Nursing Home, Baltimore, Maryland 21201

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 13-05
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3000 Keswick Road 21211

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Married	11/9/1889	75				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Maryland	

13. FATHER'S NAME: Bradley Stone

14. MOTHER'S MAIDEN NAME: Susan Schaffer

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	216-05-4517 B	Mr. Edward C. Joyce	3000 Keswick Road Baltimore, Md. 21211

MEDICAL CERTIFICATION

18. 422.1 I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: Cardio Respiratory Failure

(B) DUE TO: Congestive Heart Failure Arteriosclerotic CVHD

(C): Chronic Brain Syndrome

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov 20 1963 to May 21 1965, that (I) (we) last saw the deceased alive on May 21 1965 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Willard Appleford M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ — 23B. DATE SIGNED: 5/24/65

23C. PHYSICIAN'S NAME (Type): WILLARD APPLEFORD M.D. — 23D. ADDRESS: 5901 Park Heights Av. Baltimore

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/25/1965	Parkwood Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Faulkner	Wm. J. Tichnor & Sons	Balto. Md. 21217 North & Pa. aves.

VS 150-REV. 1/1/65

C-467 1

BIRTH NO. 65 5442

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 5442

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Daniel B. Clark

2. DATE AND HOUR OF DEATH: May 20, 1965 | 1:30 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Hopkins Apartments 3100 St. Paul Street Baltimore, Maryland 21218

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 12-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Hopkins Apartments 3100 St. Paul St. 18

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Widowed	3/17/1881	84				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Inspection	U. S. Customs	Aberdeen, Maryland	

13. FATHER'S NAME: Daniel H. Clark

14. MOTHER'S MAIDEN NAME: Sarah Greenland

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	None	Mrs. Catherine Shanahan	Route 3 Box 124 Annapolis, Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.1 I	(A) DUE TO: Coronary Occlusion	Immediate
	(B) DUE TO: Arteriosclerotic C-V Disease	10 yrs
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Pulmonary fibrosis & emphysema	10 yrs

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
6			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from January 1961 to April 20 1965, that (I) ~~(we)~~ last saw the deceased alive on April 13 1965 and that in ~~(my) (our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We) (did) (did not)~~ view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☑	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
C. Allan Smith					5/24/65

23C. PHYSICIAN'S NAME (Type) M.D. 23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/22/1965	Woodlawn Cemetery	Woodlawn, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Farber, M.D.	W. M. J. Tilghman & Sons	Balto., Md. 21217 North & Pa. Aves.

VS 150-REV. 1/1/65

K-253 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5443 Registered No. 65 5443

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Elizabeth Kesmodel

2. DATE AND HOUR OF DEATH: May 19, 1965 12 30 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Long Green Nursing Home, 115 East Melrose Avenue, Baltimore, Maryland 21212

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 2-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 116 West University Parkway 21210

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Widowed	Jan. 30, 1889	76				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	

13. FATHER'S NAME: Charles Bertram

14. MOTHER'S MAIDEN NAME: Lucette Grossman

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	213-42-2699	Mr. F. Bertram Scott	103 W. 39th Street Baltimore, Md. 10

MEDICAL CERTIFICATION

18. 422.1 I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not meon the mode of dying, e.g., heort foilure, osthemio, etc. It means the diseose, injury or complication which coused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: Congestive Heart Failure

(B) DUE TO: with Congestive Heart Failure

(C) Arteriosclerotic Cardio Vascular Disease

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if ony, giving rise to the above cause (A) stoting the UNDERLYING CONDITION lost.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Benidity

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
—			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify thot (I) (this hospital) attended the deceased from Jan 1964 to May 19 1965, thot (I) (we) last sow the deceased alive on May 19 1965 and thot in (my) (our) opinion deoth occurred on the date ond hour ond from the couses stoted above. (I) (We) (did) (did not) view the body ofter deoth.

23A. SIGNATURE: M Paul Byerly M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐ 23B. DATE SIGNED: 5/20/65

23C. PHYSICIAN'S NAME (Type): M Paul Byerly M.D. 23D. ADDRESS: 5420 York Rd

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/21/1965	Druid Ridge Cemetery	Pikesville, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Farley M.D.	Wm. J. Tichnor & Sons	Balto., Md. 21217 North & Pa. Aves

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-608 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5444 Registered No. 65 5444

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Carr, Florence

2. DATE AND HOUR OF DEATH: 5/19/65 | 9 20 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): #2 Sinai Hospital of Balto.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY: 15-D
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 4104 Pinehurst Ave, 21215

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	Never married	10-20-77	87				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Secretary	Lumber Co.	Ohio	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George R. Carr	SArah Caldwell

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	213-09-7042A	Mrs. O'Dell Long	1034 Ardsley Road Charlotte, N. C. 28207

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
1B. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) HASCVD.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(A) DUE TO	
	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
—		Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/9 19 65 to 19, that (I) (we) last saw the deceased alive on 5/16 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☑	23B. DATE SIGNED
Lee E Gresser					5/19/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Lee E Gresser		Sinai Hospital of Balto

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/21/1965	Woodlawn CEmetery	Woodlawn, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Faber, M.D.	Wm. J. Tichnor & Sons	Balto., Md. 21207 Norristown, Pa.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

SAB-43-44-561
W-536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5445 Registered No. 65 5445
M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Harry William Wentworth

2. DATE AND HOUR OF DEATH: 5-19-1965 8:20 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 9-04
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 601 East 31st Street 21218

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Divorced	7-9-1912	52				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	U.S.A.

13. FATHER'S NAME: George W. Wentworth

14. MOTHER'S MAIDEN NAME: Rosa Zinkand

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-03-3119

17. INFORMANT: Records: BCH-4940 Eastern Avenue ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. 143X I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart foilure, asthenia, etc. It means the disease, injury or complicotion which coused death.)	(A) DUE TO	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the obove couse (A) stoting the UNDERLYING CONDITION last.	(B) DUE TO	
	(C) Carcinoma of Floor of Mouth	2 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or obout home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Boltimore City, give exoct locotion)

21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospitol) ottended the deceased from 4-27- 19 65 to 5-19- 19 65, thot (I) (we) last saw the deceased alive on 5-19- 19 65 ond that in (my) (our) opinion death occurred on the dote ond hour ond from the causes stoted above. (I) (We) (did) (did not) view the body ofter deoth.

23A. SIGNATURE: C C J Carpenter M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED: 5-19-1965

23C. PHYSICIAN'S NAME (Type): C C J Carpenter M.D. 23D. ADDRESS: 4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/21/1965	Loudon Park Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Farley, M.D.	Wm. J. Fuhrman & Sons	Balto., Md. 21217 North & Pa. Aves.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

t-460

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 65 5446 Registered No. 65 5446

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JAMES P. TAYLOR

2. DATE AND HOUR PRONOUNCED DEAD: 5-19-65 | 7:15 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): MARYLAND GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 27-12
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 11 Tamworth Road 21210

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 1 Yr. Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.
Male	White	Married	1-10-1900	65				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Banking - Retired	Banking	Greenville, S. C.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Abram P. Taylor	Janie Fowlkes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
USMC	World War I		Mrs. Mary Taylor	11 Tamworth Road 21210

MEDICAL CERTIFICATION

E 900.0

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of skull and contusion of ~~XXXXX~~ mid-brain — INTERVAL BETWEEN ONSET AND DEATH

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
5-15-65	Head injury	Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Home	11 Tamworth Road - Baltimore 21210

21D. TIME OF INJURY (APPROX.) (Month)	(Day)	(Year)	(Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
5	14	'65	11:15 PM m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Fell down steps

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE Russell S Fisher M.D.
EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER [X]
ASSISTANT MEDICAL EXAMINER [ ]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 5-20-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Removal	5/21/1965	Forest Hill Cemetery	Memphis, Tennessee

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Farley, M.D.	Wm. J. Dickman & Sons	North & Pa. Aves. Balto. Md. 21217

VS 151-REV. 1/1/65

N 803.2

K-520

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5447 Registered No. 65 5447

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Maud E, King

2. DATE AND HOUR OF DEATH: May 19, 1965 | 9:30 a. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): Haven Nursing Home, 3939 Penhurst Avenue

90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 15-10
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4402 Garrison Boulevard 21215

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Single	12/12/1879	85				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired - Clerk		Maryland	

13. FATHER'S NAME: Charles Jacob King

14. MOTHER'S MAIDEN NAME: Sarah Ann Biden

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	212-12-1900	Mrs. J. Celeste B. Hampton	4402 Garrison Blvd. Baltimore, Md. 15

MEDICAL CERTIFICATION

18. 420.1 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO:

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from June 14 1955 to May 19 1965, that (I) (we) last saw the deceased alive on May 19 1965 and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Abraham B. Hurwitz M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: May 20, 1965

23C. PHYSICIAN'S NAME (Type): ABRAHAM B. HURWITZ M.D.

23D. ADDRESS: 7501 LIBERTY ROAD. BALTIMORE 7, MD

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/22/65	Loudon Park Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Parker	Wm. L. Tichnor & Sons	Balto., Md. 21217 North & Pa. aves.

VS 150-REV. 1/1/65

5-616 1

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 5448

M.E. CASE NO.

CERTIFICATE OF DEATH X

Registered No. 65 5448

1. NAME OF DECEASED (Type or Print): SCARBOROUGH, MATILDA C

2. DATE AND HOUR OF DEATH: MAY 20, 1965 | 12:00P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location): ST. AGNES HOSPITAL

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: 99

C. CITY OR TOWN (If outside city limits, write RURAL and give township): GLEN BURNIE P.O. 32-00

D. STREET ADDRESS (If rural, give location): RT 1 BOX 288 N

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	WHITE	WIDOWED	11-27-89	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE	NONE	MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
WILLIAM	CATHERINE RUPPERT

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NONE	216-10-3085	ST. AGNES HOSPITAL RECORDS; CATON & WILKENS AVES

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute diverticulitis —

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) C.V.A a/t surgery —

DUE TO

(C) Acute pulmonary edema

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
/			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from MAY 5 19 65 to MAY 20 19 65, that (I) (we) last saw the deceased alive on MAY 20 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☑	23B. DATE SIGNED
Anna Santos					5,20,65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
A. SANTOS M.D.	#29 ST. AGNES HOSPITAL; CATON & WILKENS AVE

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/22/65	Baltimore Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 24 1965	Robert E. Farley, M.D.	Wm. J. Tickner - No. Pa Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5/26/65 - Operation - 5/12/65 - Hysterectomy
Information received via phone call
from St. Agnes Hosp. -

C-460 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5449 Registered No. 65 5449

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Sophie Cihlar

2. DATE AND HOUR OF DEATH: May 19, 1965 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION: Union Memorial Hosp.
(If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 524 N. Milton Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F.	W.	Widow	March 19, 1880	85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home		maryland	

13. FATHER'S NAME: Joseph Hlavin

14. MOTHER'S MAIDEN NAME: Mary Humpal

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Barbara Valentini	1902 Burnwood Ave.

MEDICAL CERTIFICATION

18. #20.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Chronic hypertension	Jan 1-65
DUE TO (B)	Arteriosclerotic heart disease	do
DUE TO (C)	Coronary heart disease	May 19-65

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0 —	—		

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 1 1965 to May 19 1965, that (I) (we) last saw the deceased alive on May 19 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☒	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
F. Frederick Ruzicka					May 21-1965

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
F. Frederick Ruzicka		800 N. Patterson Park Ave.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-22-65	Most Holy Redeemer	Baltimore, Md. 6

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 24 1965	Robert E. Farley M.D.	Frank Cvach & Son, 900 N. Chester St. 5

VS 150-REV. 1/1/65

1

BIRTH NO. 65 5450

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5450

M.E. CASE NO.

5-432

1. NAME OF DECEASED (Type or Print)	HARRY FRANKLIN SCHULTZ Jr.
2. DATE AND HOUR PRONOUNCED DEAD	May 19, 1965 11:00 P M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)	University Hospital
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE	Maryland
B. COUNTY	21-02
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	Baltimore
D. STREET ADDRESS (If rural, give location)	925 McHenry Street
5. SEX	Male
6. RACE	White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	Single
8. DATE OF BIRTH	November 19, 1929
9. AGE (In years last birthday)	35
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Laborer
10B. KIND OF BUSINESS OR INDUSTRY	Book Binding Shop
11. BIRTHPLACE (State or foreign country)	Martinsburg, West Virginia
12. CITIZEN OF WHAT COUNTRY?	USA
13. FATHER'S NAME	Harry Albert Schultz
14. MOTHER'S MAIDEN NAME	Mary Irene Grove
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	No / None
16. SOCIAL SECURITY NO.	220-26-5233
17. INFORMANT ADDRESS	Mrs. Irene Schultz 925 McHenry St., Baltimore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

421.4 I

(A) Multiple Organizing Pulmonary Emboli

DUE TO

ANTECENDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Chronic Endocarditis.

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Petty M.D.

EXAMINER'S NAME (Type) Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 5/20/65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/22/65	Silver Grove Cemetery	Silver Grove W. Va.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Farley M.D.	Donald Eackles	Harpers Ferry, W.Va.

VS 151-REV. 1/1/65

W-3621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5451 Registered No. 65 5451

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Pearl L. Waters

2. DATE AND HOUR OF DEATH: May 19, 1965 — 3 30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 4413 Kathland Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 28-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4413 Kathland Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Single	June 19, 1886	78				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore, Md.	U.S.A.

13. FATHER'S NAME: Isiah Waters

14. MOTHER'S MAIDEN NAME: Kate Ripnick

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-44-3932

17. INFORMANT: Helen Becker. ADDRESS: 4413 Kathland Ave Baltimore, Md. 21207

MEDICAL CERTIFICATION

18. 443 X 1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cerebral Vascular Accident — 1 day
DUE TO
(B) Hypertensive C.V. Disease — 5 years
DUE TO
(C) Chronic Congestive Heart Failure — 3 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes / No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED — While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from APRIL 1 1959 to MAY 19 1965, that (I) (~~we~~) last saw the deceased alive on MAY 19 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Thomas E. Wheeler M.D. — Attending Phys. ☑ Med. Director ☐ Stoll Phys. ☐ — 23B. DATE SIGNED: 5/19/65

23C. PHYSICIAN'S NAME (Type): THOMAS E. WHEELER M.D. — 23D. ADDRESS: 3601 CLIFFMAR RD — BALTO 7 - MD

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	May 22, 1965	Woodlawn	Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: MAY 24 1965 — 25B. NAME OF REGISTRAR: Robert E. Faber, M.D. — 25C. FUNERAL DIRECTOR: Harry J. Armacost — ADDRESS: 4204 Ridgewood Ave Baltimore, Md. 21215

VS 150-REV. 1/1/65

A-6330 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5452 Registered No. 65 5452

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Louis Howard

2. DATE AND HOUR OF DEATH 5/18/65 | 9 30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion) UNION MEMORIAL Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township) PIKESVILLE 5300
D. STREET ADDRESS (If rural, give location) 23 RANDALL AVE.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	W	10/15/05	59				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
POLICEMAN	SAME	MARYLAND	U.S.A.

13. FATHER'S NAME Edward Dickson Howard

14. MOTHER'S MAIDEN NAME Julia Green

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
UNK	NO	220-44-6285	BROTHER	UNK

MEDICAL CERTIFICATION

18. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode al dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complicatian which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO Myocardial infarct, acute

(B) DUE TO E Rupture and hemo-

(C) pericardium HRB

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		YES	YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factary, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify thot (he) (this hospitol) ottended the deceased from 5/13 19 65 to 5/18 19 65, that (I) (we) last sow the deceosed olive on 5/18 19 65 ond thot In (my) (our) opinion deoth occurred on the dote ond hour ond from the couses stoted above. (I) (We) (did) (did not) view the body ofter deoth.

23A. SIGNATURE William N. Bennett M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED 5/18/65

23C. PHYSICIAN'S NAME (Type) William N. Bennett WILLIAM N. BENNETT M.D. 23D. ADDRESS Union Memorial Hospital UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-20-65	Meadow Branch	Carroll Co Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Falkenhan	Frank H. Mezick & Sons	Pikesville Md

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-635 1

BIRTH NO. 65 5453

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5453

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): HERBERT LEROY BURTON

2. DATE AND HOUR OF DEATH: 5/19/65 — 3:30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CERTIFICATE CORRECTED 6/2/65 6700 RAILWAY AVENUE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD. B. COUNTY: 26-36
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE ~~21221~~ 21222
D. STREET ADDRESS (If rural, give location): 6700 RAILWAY AVENUE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	CAUCASIAN	MARRIED	3/24/1887	104 / 78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SUPT.	PAINT MFGR.	MARYLAND	USA

13. FATHER'S NAME: CALEB C. BURTON

14. MOTHER'S MAIDEN NAME: RUTH DAWSON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 217/03/3184A

17. INFORMANT: ANNA GRAY BURTON (WIDOW) ABOVE — ADDRESS: SEE #4

MEDICAL CERTIFICATION

1B. 450.01

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) SEPTICEMIA

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

DUE TO (B) MULTIPLE DECUBITUS ULCERS

DUE TO (C) GENERALIZED ARTERIOSCLEROSIS 10 YRS

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 19 60 to May 19 19 65, that (I) (we) last saw the deceased alive on May 19 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Stephen C. Mackowiak M.D. — Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐ — 23B. DATE SIGNED: 5-21-65

23C. PHYSICIAN'S NAME (Type): STEPHEN C, MACKOWIAK M.D. — 23D. ADDRESS: 6714 HOLABIRD AVE., BALTO., MD.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/22/65	WAUGH C.M.CEMETERY	HARFORD, COUNTY, MD.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Farley, M.D.	W. BROOKS BRADLEY	DUNDALK, MD.

VS 150-REV. 1/1/65

Baptismal Record. 6/2/65 C. P. Bowens

T46T

1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5454 Registered No. 65 5454

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): ZACARIAS --- TOLARBA

2. DATE AND HOUR OF DEATH: MAY 22, 1965 | 9:35 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
U.S. Public Health Service Hospital
31st & Wyman Park Drive
Baltimore, Maryland 21211

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore 11-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 506 North Howard Street. Zone 1

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	Malayan	Single	JAN 7, 1901	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
US Army, enl. Retired		Philippine Islands	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Victorino Tolarba	unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	5/8/23 -- 7/31/53	215-34-7659	Patient's chart, AND, Discharge Certificates from U.S. Army.	

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Gram negative septicemia — INTERVAL BETWEEN ONSET AND DEATH: 18 days

DUE TO

(B) Left hepatic duct obstruction (stone) and right hepatic abscesses — Over 25 days

DUE TO

(C) Ascending cholangiitis, suppurative, — 22 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
5/14/65	Ascending Cholangitis, Biliary Stones.	YES	YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
NO	Not applic.	Not applic.

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
Not applic.	While At Work ☐ Not While At Work ☐	Not applic.

22. I certify that (X) (this hospital) attended the deceased from May 4, 1965 to May 22, 1965, that (X) (we) last saw the deceased alive on May 22, 1965 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did) (XXXX) view the body after death.

23A. SIGNATURE: James H. Frank, M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. XX — 23B. DATE SIGNED: May 24, 1965

23C. PHYSICIAN'S NAME (Type): James H. Frank, M.D. SURG (R) USPHS — 23D. ADDRESS: U.S. Public Health Hospital, Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/26/65	Baltimore National Cemetery	Fredrick Ave. Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Farley, M.D.	Wm. Cook-Brooks Inc.	1217 St. Paul St. Baltimore 2, Md.

VS 150-REV. 1/1/65

J-520 1

BIRTH NO. 65 5455

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 5455

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): George W. Jones

2. DATE AND HOUR OF DEATH: 5/18/65 | 5:50 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 18 Kinship Rd.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	Widowed	8-2-79	85				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
STATIONARY ENGINEER	Std. Oil	Maryland	USA

13. FATHER'S NAME: Samuel Jones

14. MOTHER'S MAIDEN NAME: Annie Reese

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 215-07-1378

17. INFORMANT: Chart ADDRESS:

MEDICAL CERTIFICATION

18. 570.2 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO: gangrene of the ileum — INTERVAL BETWEEN ONSET AND DEATH: 3-4 days

(B) DUE TO: omental band, constricting

(C):

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 5/17 1965 to 5/18 1965, that ~~(I)~~ (we) last saw the deceased alive on 5/18 1965 and that In(my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (did ~~not~~) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
John J. Conroy		☐	☐	☑	5/19/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
John J. Conroy		Church Home & Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/21/65	OAK LAWN CEMETERY	BALTIMORE CO. MD

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 24 1965	R. C. & E. Farber, M.D.	ULLRICH FUNERAL HOME DUNDALK MD

VS 150-REV. 1/1/65

1

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 5456 65-00130 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No. 65 5456

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): DWAIN RICE DWAYNE

2. DATE AND HOUR PRONOUNCED DEAD: May 19, 1965 11:00 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-02
D. STREET ADDRESS (If rural, give location): 619 W. Lafayette Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
male	colored	Single	Jan. 1, 1965		4			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore, Md.	

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Barbara Stepto

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Marie Johnson	619 W. Lafayette Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

E924.0

(A) Asphyxia

DUE TO

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Plastic sheet over mouth

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS ☒ UNDERLYING OR ☐ CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Home	619 W. Lafayette Avenue 17-02

21D. TIME OF INJURY (APPROX.) (Month)	(Day)	(Year)	(Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
5	19	65	? m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Allegedly plastic bag over mouth

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): R. Breitenecker M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 5-19-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5/22/65	Mt. Auburn	Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 24 1965	Rolse E. Faber, M.D.	Arlington S. Phillips 1727 N. Monroe St.

VS 151-REV. 1/1/65

N 991 X

Broughman, Virgie
115 78 9876 B 625

Released Non-Med Dr. Linthicum

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5457 Registered No. 65 5457

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) VIRGIE L. BROUGHMAN — Broughman Virgie

2. DATE AND HOUR OF DEATH: 5-22-65 — 4:04 pm M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. — B. COUNTY: 7-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 825 S. Bond St

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	Widowed	July 29, 1908	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	West Virginia	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Dale Payne	Sarah Rye

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	233-56-8141	William L. Broughman	825 S. Bond Street

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: Myocardial Infarction — 60 min.
(B) DUE TO: Arteriosclerotic Heart Disease — —
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Diabetes Mellitus — 6 yrs

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-22 19 65 to 5-22 19 65, that (I) (we) last saw the deceased alive on 5-22 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
James W. Keller					5-22-65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
James W. Keller		Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-26-1965	Cedar Hill	Anne Arundle County, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Farley, M.D.	Lilly & Zeiler Inc.	1901 Eastern Ave.

VS 150-REV. 1/1/65

L-342 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5458 Registered No. 65 5458

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Charles A. Leidlich

2. DATE AND HOUR OF DEATH: May 20, 1965 | 5:47 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2642 Guilford Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): ~~No.~~ 2642 Guilford Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	Feb. 2, 1890	75				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Dept. Store Supt.	Retired	Baltimore, Md.	

13. FATHER'S NAME: John Leidlich

14. MOTHER'S MAIDEN NAME: Sophia Lehman

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	W W 1	212-09-9092	Mrs May J. Leidlich	2642 Guilford Ave

MEDICAL CERTIFICATION

18. 332X I — CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Thrombosis Cerebralartery — Interval between onset and death: 8 Days
DUE TO
(B) Arteriosclerosis — 3 Years
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. none

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
None		

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
None	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (This hospital) attended the deceased from May 18, 1965 to May 20, 1965 ######## that (I) ## last saw the deceased alive on May 19, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
A. S. Chalfant	M.D.	X	☐	☐	

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
A. S. Chalfant M.D.	6210 York Rd. Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/24/65	Baltimore National	Baltimore

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Farley M.D.	[signature]	1913 W. Balto. St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

G-456

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 5459 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No. 65 5459

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ANTHONY GILMORE	2. DATE AND HOUR PRONOUNCED DEAD 5-23-65 6:50 P.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): ST. JOSEPH'S HOSPITAL - DOA	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore; D. STREET ADDRESS (If rural, give location) 1432 N. Bond Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Colored	Married	Feb. 28, 1893	72				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Streetcar		Glenn Springs S.C.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Columbus Gilmore	Mattie Turner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes World War I	218-07-6181	Lolar Gilmore	1432 N. Bond St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that an this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Russell S Fisher M.D.

EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 5-24-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Removal	May 27 '65		Spartanburg S.C.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robt E. Falkner	Wolff-Eichner	1129 N. Gilmor

VS 151-REV. 1/1/65

65 5460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5460

BIRTH NO.

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): WATSON, BESSIE

2. DATE AND HOUR OF DEATH: 5/20/65 | 3 27 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CERTIFICATE CORRECTED 6/9/65 Sinai Hospital of Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 15-10
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4123 Granada Ave

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	N	WIDOWED DIVORCED	7/8/1901	64				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Webb
14. MOTHER'S MAIDEN NAME: Dorthy Peoples

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No.
16. SOCIAL SECURITY NO.:
17. INFORMANT: Lucille Jeffries ADDRESS:

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Acute + Chronic Cor Pulmonale	6 months
	DUE TO (B) Pulmonary Sarcoidosis	2 years
ANTECEDENT CAUSES: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	DUE TO (C) Boeck's Sarcoid	?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

MEDICAL CERTIFICATION

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from AUGUST 1946 to MAY 20 1965, that (I) (~~we~~) last saw the deceased alive on 5/20 1965 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: John M. Scott M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 5/20/65
23C. PHYSICIAN'S NAME (Type): JOHN M. SCOTT M.D.
23D. ADDRESS: 600 W. BELVEDERE AVE., 10

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 5-25-65
24C. NAME of CEMETERY or CREMATORY: MT. Auburn Cem.
24D. LOCATION (City, town, or county) (State): BALTimore Md.

25A. DATE REC'D BY HEALTH DEPT.: MAY 24 1965
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: E. O. Wilson
ADDRESS: 1000 Brentley Ave.

VS 150-REV. 1/1/65

1

F-520

BIRTH NO. 65 5461

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5461

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) EVA FINCH

2. DATE AND HOUR PRONOUNCED DEAD May 19, 1965 12:30 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 17 N. Castle St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6-04
D. STREET ADDRESS (If rural, give location) 17 N. Castle St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
female	colored	Married		49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	None	N. Carolina	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO			

MEDICAL CERTIFICATION

18. 443 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease

DUE TO

ANTECENDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) Rudiger Breitenecker M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 5-19-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5-24-65	Mt. Auburn Cem	Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Farley M.D.	E. D. Wilson	1000 Bromley Ave

VS 151-REV. 1/1/65

43-35-10 A1

W-400

1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5462 Registered No. 65 5462

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Laverne Wiley

2. DATE AND HOUR OF DEATH: 5-20-65 | 8:45 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 44
C. CITY OR TOWN (If outside city limits, write RURAL and give township): 52-00
D. STREET ADDRESS (If rural, give location): 6401 Ritchie Highway

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	Negro	Married	12-26-08	56				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	None	Maryland	U. S. A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		RECORDS: B.C.H.	4940 Eastern Avenue #21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia Secondary to Kimmelstiel Wilson Disease. — INTERVAL BETWEEN ONSET AND DEATH: 4 Years

DUE TO

(B) Diabetes Mellitus — 12 Years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-15 19 65 to 5-20- 19 65, that (I) (we) last saw the deceased alive on 5-20- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
C. Carpenter					5-20-65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Dr. Charles Carpenter		4940 Eastern Avenue #21224

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-25-65	Mt. Calvary Cem.	Brooklyn, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Farley, M.D.	E. O. Wilson	1000 Brantley Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-620 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5463 Registered No. 65 5463

1. NAME OF DECEASED (Type or Print): PERLEY BRUCE

2. DATE AND HOUR OF DEATH: 7:45 AM 5/23/65 A.M. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL. BALTIMORE, MARYLAND 33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 8-06
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1703 CRYSTAL AVENUE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	N.	WIDOWER	8-29-90	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retire	Bethlehem Steel Co	MT. Airey, Md.	U.S.A

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: LUEVINIA BRUCE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) DUE TO: CARCINOMA OF BILE DUCT — INTERVAL BETWEEN ONSET AND DEATH: 7
(B) DUE TO: HEMORRHAGIC DIATHESIS — 2d.
(C) DUE TO: HYPOTENSION & CARDIAC ARREST — 2d.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
5/11/65	CA. COMMON BILE DUCT	NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 16 1965 to May 23 1965, that (I) (we) last saw the deceased alive on May 23 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J. Gregory Kane M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 5/23/65
23C. PHYSICIAN'S NAME (Type): J. GREGORY KANE M.D.
23D. ADDRESS: JHH

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-26-65	Mt. Calvary Cem.	Brooklyn, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 24 1965	Robert E. Faulkner M.D.	C. O. Wilson 1000 Brantley Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-655 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5464 Registered No. 65 5464

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Agustina Fernandez M.

2. DATE AND HOUR OF DEATH: May 21, 1965 11:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 604 McKewin Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 9-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 604 McKewin Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	Never Married	3/15/1868	97		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Homemaker	Own Home	Puerto Rico	U.S.A.

13. FATHER'S NAME: Manuel Fernandez M.

14. MOTHER'S MAIDEN NAME: Carmen Mascaro

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Manuel J. Travieso,	6009 Sycamore Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1939 19 ___ to May 21 19 65, that (I) (We) last saw the deceased alive on May 21 19 65 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Wm G. Helfrich M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: May 21, 1965

23C. PHYSICIAN'S NAME (Type): William G. Helfrich M.D.

23D. ADDRESS: 5006 Roland Ave., Balto.10, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/24/1965	Holy Redeemer	Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 24 1965	Robert E. Farley, M.D.	H.W.Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md.

VS 150-REV. 1/1/65

M-320 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5465 Registered No. 65 5465

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): MATTHEW PHYLLIS SCARTH

2. DATE AND HOUR OF DEATH: 5/23/65 | 5 45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD B. COUNTY: Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALT. 53-00
D. STREET ADDRESS (If rural, give location): 6828 QUEENS FERRY RD

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	M	12/29/94	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HSWF	NONE	CANADA	CANADA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
ARTHUR TREMAINE	ANNIE DALKIN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No —	—	UMH CHART	CITY

MEDICAL CERTIFICATION

18. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
(A)	ACUTE RENAL FAILURE	3 DAYS
DUE TO (B)	CARDIOVASCULAR SHOCK	5 DAYS
DUE TO (C)	ACUTE MYOCARDIAL INFARCTION	6 DAYS

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
NONE	—	No	—

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work ☐ — Not While At Work ☐	21F. HOW DID INJURY OCCUR?
—		—

22. I certify that (I) (this hospital) attended the deceased from 5/17/19 65 to 5/23/19 65, that (I) (we) last saw the deceased alive on 5/23/19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE				23B. DATE SIGNED
A. Laird Bryson M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☑	5/23/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
A. LAIRD BRYSON, M.D.	UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	5-26-65	Mt. Royal	Montreal	Canada

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 24 1965	Robert E. Farley M.D.	H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.

VS 150-REV. 1/1/65

P-412 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5466 Registered No. 65 5466

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): PHILLIPS FRANCIS ZAVIER

2. DATE AND HOUR OF DEATH: 5/22/65 10:35 A.M.

CERTIFICATE CORRECTED 5-25-65

3. PLACE OF DEATH IN BALTIMORE, MARYLAND (If not in hospital or institution, give street address or location)
FULL NAME OF HOSPITAL OR INSTITUTION: UNION MEMORIAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY: 9-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): ~~605~~ ~~PARK~~ 3807 GREENMOUNT AVE.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	M	11/8/04	60				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED CLERK	GOV'T.	BALTIMORE	U.S.

13. FATHER'S NAME: ~~FRANCIS Z.~~ JAMES P. PHILLIPS

14. MOTHER'S MAIDEN NAME: ANNIE KEARNS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	218-32-0394	MRS. MARY J. PHILLIPS	SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

260 X I

(A) DUE TO: Diabetes mellitus with severe generalized arteriosclerosis and gangrene of both feet
(B) DUE TO: Calcific coronary artery disease & ischemia of the left ventricle.
(C) Atrophy of pancreas, apex of the head of the pancreas.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/14/65 19__ to 5/22/65 19__, that (I) (we) last saw the deceased alive on 5/22 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☑	23B. DATE SIGNED
Wallace					5/22/65

23C. PHYSICIAN'S NAME (Type): S. SAMAAN
23D. ADDRESS: Union Memorial Hosp

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/25/1965	New Cathedral	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 24 1965	Robert E. Farley, M.D.	H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md.

VS 150-REV. 1/1/65

B-3461

BIRTH NO. 65 5467

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5467

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): BUTLER, Ruth N.

2. DATE AND HOUR OF DEATH: MAY 21st 1965 | 7 10 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 27-38
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5725 The Alameda

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	Married	1/7/1908	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Baltimore, Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Richard J. Norwood	Matilda Schwartzmann

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	217-26-4932	Ira G. Butler	(Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) OCCLUSION of CORONARY ARTERY — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

DUE TO

(B) ARTERIOSCLEROTIC HEART DISEASE — INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO

(C) —

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
NONE	—	No	—

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
NONE	—	—

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
—	While At Work ☐ Not While At Work ☐	—

22. I certify that (I) (~~this hospital~~) attended the deceased from — 1940 to May 21st 1965, that (I) (~~we~~) last saw the deceased alive on May 21st 1965 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
A.S. Chalfant M.D.	☒	☐	☐	May 21st 1965

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Dr. A.S. CHALFANT M.D.	6210 YORK ROAD BALTIMORE 12 Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/25/1965	Cedar Hill	5829 Ritchie Hywy. A.A. Cty. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Farley, M.D.	H.W. Jenkins & Sons Co.	4905 York Rd. Balto. 12, Md.

VS 150-REV. 1/1/65

K-462 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5468 Registered No. 65 5468

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): JOHN R. KELEHAR

2. DATE AND HOUR OF DEATH: MAY 21, 1965 | 12-40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): EDGEWOOD NURSING HOME 6000 BELLONA AVE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: CONN B. COUNTY: K-06
C. CITY OR TOWN (If outside city limits, write RURAL and give township): DERBY
D. STREET ADDRESS (If rural, give location): 66 ELIZABETH STREET

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
FEMALE	WHITE	SINGLE	JULY 5, 1883	81 YRS				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED MGR D.H. KELLY CO		DERBY, CONN	

13. FATHER'S NAME: MILES H. KELEHER

14. MOTHER'S MAIDEN NAME: MARY E. KELLY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	044-09-1768	MR. V.P. KELEHAR	BROADVIEW APTS

MEDICAL CERTIFICATION

CAUSE OF DEATH

	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	INTERVAL BETWEEN ONSET AND DEATH
I 1B. 260X	(A) Coronary Thrombosis	minutes
	DUE TO (B) Acute Arteriosclerosis	Years
ANTECEDENT CAUSES: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	DUE TO (C) Diabetes Mellitus	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ____ 19__ to 5/24 19 65, that (I) (we) last saw the deceased alive on 5/24 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☑	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
Robert C. Duvall					5/21/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
ROBERT C. DUVALL		MEDICAL ARTS BLDG. BALTO. MD.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/25/65	MT. ST. PETER'S	DERBY, CONN

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robt E. Fahrney	H. W. MEARS & SON	805 N. CALVERT ST.

VS 150-REV. 1/1/65

Z-100 1

BIRTH NO. 64-25435 65 5469

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5469

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Zuby, Kathleen

2. DATE AND HOUR OF DEATH: 5/20/65 | 8:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore County
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Essex, 21221
D. STREET ADDRESS (If rural, give location): 278 Holly Neck Rd.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	Child	9/14/64		8	6		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Child	child	Baltimore, Md.	USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: JUSTINE ZUBY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	None	Charts	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. it means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO	Atelectasis & Pneumonia	12 days
(B) DUE TO	VSD (Congenital) & congestive	
(C)	heart failure	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
None		Pending YES	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No		

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ — Not While At Work ☐	21F. HOW DID INJURY OCCUR?
—		

22. I certify that (I) (this hospital) attended the deceased from 1 May 19 65 to 20 May 19 65, that (I) (we) last saw the deceased alive on 20 May 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
Rufus B. Jennings, Jr.					20 May 65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Rufus B. Jennings Jr.		The Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5-22-65	SACRED HEART OF JESUS	BALTIMORE CO. MARYLAND

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Farley, M.D.	James C. Szczypinski	1402 EASTERN AVE.

VS 150-REV. 1/1/65

K-225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5470 Registered No. 65 5470

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Ethel Eugenia Kasecamp

2. DATE AND HOUR OF DEATH: 5-21-65 | 8 50 4. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): 3611 E. NORTHERN PARKWAY

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: ALLEGANY

C. CITY OR TOWN (If outside city limits, write RURAL ond give township): CUMBERLAND 5/-02

D. STREET ADDRESS (If rurol, give locotion): 202 SPRING STREET

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In yeors lost birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White		1/29/90	75				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE		WEST VIRGINIA	USA

13. FATHER'S NAME: FRANK J. CAMPBELL

14. MOTHER'S MAIDEN NAME: ANNA MC LAUGHLIN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		MRS. ROBT. MEGEE	3611 NORTHERN PRKY.

MEDICAL CERTIFICATION

18. 179.2 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the diseose, injury or complicotion which caused deoth.)

CAUSE OF DEATH

(A) Cancer, origin unknown DUE TO

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: (A) 4 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the obove couse (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Boltimore City, give exoct locotion)

21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from April 20, 1965 to May 21, 1965, that (I) (~~we~~) last saw the deceased alive on April 20, 1965 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
R Donald Jandorf M.D.	Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐	5-21-65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
R Donald Jandorf M.D.	6077 Harford Rd.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/24/65	HILLCREST BURIAL PARK	CUMBERLAND, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 24 1965	Robert E. Farley M.D.	GEORGE FUNERAL HOME, CUMBERLAND, MD.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-300 1

BIRTH NO. Cumberland, Md. Valerie Hiett 65 5471

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 5471

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): VALERIA LYNN HIETT

2. DATE AND HOUR OF DEATH: May 21, 1965 | 4:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): ~~Mercy Hospital~~ MERCY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Allegany
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Cumberland
D. STREET ADDRESS (If rural, give location): 57-00

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	WHITE	baby	April 25, 1965	26 days		26		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CHILD		Balto, Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Hiett	Marilyn Shipley

15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO	NONE	JOSEPH HIETT, CUMBERLAND, MD.

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Sepsis	4 days
ANTECEDENT CAUSES	(B) DUE TO ~~Arnold~~ Hydrocephalus	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(C) Arnold Chiari Malformation.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Rt Ventricular - Atrial Shunt	

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
5-14-65	Hydrocephalus	No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/11 1965 to 5/21 1965, that (I) (we) last saw the deceased alive on 5/21 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☑	23B. DATE SIGNED
Willard E. Standiford					5/21/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Willard E. Standiford		Mercy Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/23/65	SUNSET MEMORIAL PARK	CUMBERLAND, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 24 1965 Roberts	E. Farley, M.D.	SCARPELLI FUNERAL HOME, CUMBERLAND, MD.

VS 150-REV. 1/1/65

D-652 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M.E. CASE NO. 65 5472 Registered No. 65 5472

1. NAME OF DECEASED (Type or Print): William H. Deering, Sr.

2. DATE AND HOUR OF DEATH: 5-20-65 2:14 a.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 269 Oaklee Village - 21229

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 21229
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 25-41
D. STREET ADDRESS (If rural, give location): 269 Oaklee Village

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	2-18-1886	79				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Warehouseman		Maryland	

13. FATHER'S NAME: August Deering

14. MOTHER'S MAIDEN NAME: Barbara Killion

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Mrs. Edith M. Deering-269 Oaklee Village	21229

MEDICAL CERTIFICATION

1B. 155.01

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Primary Carcinoma of Liver confirmed

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO:

(C): by Laparotomy & Biopsy

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Apr 1 1965 to May 20 1965; that (I) (~~we~~) last saw the deceased alive on May 19 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (~~did not~~) view the body after death.

23A. SIGNATURE: B. Brumbaugh M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐ 23B. DATE SIGNED: 5/21/65

23C. PHYSICIAN'S NAME (Type): Bruce Brumbaugh M.D. 23D. ADDRESS: 5609 Main Street, Elkridge, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-22-65	Loudon Park Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Farley M.D	Howard H. Hubbard-4107 Wilkens Ave	21229

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

K-656

BIRTH NO. 65 5473

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 5473

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CHARLES E. KAMMER

2. DATE AND HOUR PRONOUNCED DEAD: 5/20/65 8:55 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — CERTIFICATE CORRECTED 5-27-65
(FULL NAME OF HOSPITAL OR INSTITUTION) (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
2223 E. Biddle St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2223 E. Biddle St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
male	white	Single	April 19, 1914	51		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Oiler	American Standard	Balto. Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John W. Kammer	Jennie Hildebrandt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	215-10-0032	George P. Kammer	2223 E. Biddle St

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 5811

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fatty liver Acute Ethylism
DUE TO
(B)
DUE TO
(C)

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Fatty Liver

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		yes	yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED 5/21/65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5-24-65	Baltimore Cemetery	Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Faulkner	John C. Miller Inc	6415 Belair Rd.

VS 151-REV. 1/1/65

#6

Letter from M.E's office
5-27-65 M.H.

P-262 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5474 Registered No. 65 5474

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): PISARSKI, EDMUND S.

2. DATE AND HOUR OF DEATH: 5-21-65 2:10A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: BALTO.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE ZONE 21227
D. STREET ADDRESS (If rural, give location): 5564 LINK AVENUE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
MALE	WHITE	WIDOWED	10-28-94	70				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Gas & Elec. Co.	ILLINOIS	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Pisarski	AGUSTA

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
YES WW ONE	219223546	ST. AGNES RECORDS -CATON & WILKENS

MEDICAL CERTIFICATION

18. 163X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: Carcinoma of Lung — Months -

(B) DUE TO:

(C):

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from MAY 13 19 65 to MAY 21 19 65, that (I) (we) last saw the deceased alive on MAY 21 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.O.				23B. DATE SIGNED
Richard J Kelly		Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	5/21/65

23C. PHYSICIAN'S NAME (Type)	M.O.	23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/24/65	Baltimore National Cem.	Baltimore, Marvland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 24 1965	Robert E. Faulkner	Walters Funeral Home- Pratt & Strickers

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

I-625 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5475 Registered No. 65 5475

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): IRRGANG, GEORGE J.

2. DATE AND HOUR OF DEATH: MAY 21, 1965 2:30P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location): ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence beloro odmission)
A. STATE: MARYLAND B. COUNTY: Howard
C. CITY OR TOWN (If outside city limits, write RURAL and give township): ELLICOTT CITY
D. STREET ADDRESS (If rurol, give location): 21 ALICE AVE.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In yeors lost birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	WHITE	WIDOWED	12-7-91	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED	RETIRED GAS & ELECTRIC	WISCONSIN	U.S.A.

13. FATHER'S NAME: JOSEPH IRRGANG

14. MOTHER'S MAIDEN NAME: CAROLINE ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): YES

16. SOCIAL SECURITY NO.: 212-05-4802

17. INFORMANT: ST. AGNES HOSPITAL RECORDS; CATON & ADDRESS: WILKENS AVES

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not meon the mode of dying, e.g., heort failure, asthenia, etc. It means the diseose, injury or complicotion which coused deoth.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the obove couse (A) stating the UNDERLYING CONDITION last.

(A) DUE TO: Generalized ASCVD
(B) DUE TO: Recent Massive Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: ~24 hrs
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Passive Congestion

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		yes	yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from MAY 21 19 65 to MAY 21 19 65, that (I) (we) last saw the deceased alive on MAY 21 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
Frank M Detorie MD		☐	☐	☒	5/22/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
FRANK M DETORIE		STAGNES HOSP BALTO.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	5/24/65	LORRAINE	WOODLAWN BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Farley M.D.	John T. Hansbury	6411 Reisterstown Rd

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

S-160

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 5476 M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5476

1. NAME OF DECEASED (Type or Print): RUTH V. SHAVER

2. DATE AND HOUR OF DEATH: 5/22/65 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 5322 Wesley Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY 28-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5322 Wesley Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Married	11/8/1883	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home		Maryland	U.S.A.

13. FATHER'S NAME: William H. Hoffman

14. MOTHER'S MAIDEN NAME: Hastings

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	Harvey S. Shaver	5322 Wesley Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
I 332 X	(A) CEREBRO-VASCULAR THROMBOSIS	5 DAYS
	DUE TO (B) ARTERIOSCLEROSIS	15 YRS.
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	BRONCHOPNEUMONIA	5 DAYS

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from APRIL 20, 1953 to MAY 22, 1965, that (I) (we) last saw the deceased alive on MAY 22, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE	M.D.	23B. DATE SIGNED
Marvin Goldstein	Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐	MAY 22, 1965

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
MARVIN GOLDSTEIN M.D.	5334 LIBERTY HEIGHTS AVE., MD.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/25/65	Woodlawn Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Tasker, M.D.	Ellsworth Armacost	Ellsworth Armacost 4600 Liberty Heights

VS 150-REV. 1/1/65

J-520 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5477 Registered No. 65 5477

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): HAZEL ADELE JONES

2. DATE AND HOUR OF DEATH: MAY 23, EST 1:10 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): THE HOSPITAL FOR THE WOMEN OF MARYLAND.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: BALTIMORE City
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE City
D. STREET ADDRESS (If rural, give location): 3623 FAIRVIEW AVE. 15-38

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 9-23-1901
9. AGE (In years last birthday): 63
If Under 1 Yr. Months: Days:
If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary
10B. KIND OF BUSINESS OR INDUSTRY: CHARLES A WILSON & CO.
11. BIRTHPLACE (State or foreign country): BALTIMORE
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Ellsworth JONES
14. MOTHER'S MAIDEN NAME: Mary Cissy Hood - (Dec)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No.
16. SOCIAL SECURITY NO.: Yes
17. INFORMANT: CHARLES A WILSON, CHART STEVENSON, Md ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Metastatic (widespread). cystadenocarcinoma (from ovary).
(B) DUE TO:
(C):

INTERVAL BETWEEN ONSET AND DEATH: since March 1964

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from MAY 23 19 65 to MAY 23 19 65, that (I) (we) last saw the deceased alive on MAY 23 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Stoll Phys. ☑
23B. DATE SIGNED: 5-23-65
23C. PHYSICIAN'S NAME (Type): A. A. MENDOZA M.D.
23D. ADDRESS: WOMEN'S HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 5-25-65
24C. NAME of CEMETERY or CREMATORY: Druid Ridge Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: MAY 24 1965
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR ADDRESS: Ellsworth Arnecost 4601 Liberty Heights

VS 150-REV. 1/1/65

L-50(3) 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5478 Registered No. 65 5478

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Clara L. Lane

2. DATE AND HOUR OF DEATH: 5/21/65 2 40 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balto 28 02
C. CITY OR TOWN, (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5310 Gwynn Oak Ave

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Widowed	6/3/1875	89				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John A. Gordon	Caroline V. Hopkins

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	None	Elva Moore 5310 Gwynn Oak Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
I (A) DUE TO	Acute pulmonary edema and Possible Pneumonitis	48 hours
(B) DUE TO	Granulocytic leukemia	2 months
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/19 19 65 to 5/21 19 65, that (I) (we) last saw the deceased alive on 5/21 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
Donald Eiel					5/21/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
M.D.	Sinai Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/24/65	Loudon Park Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Farley, M.D.	Ellsworth Armacost	Ellsworth Armacost 4600 Liberty Heights

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-5661
49-66-40 AM 1

BIRTH NO. 65 5479

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 5479

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): John M. Sommer

2. DATE AND HOUR OF DEATH: 5-23-65 | 1:30 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION: Baltimore City Hospitals
(If not in hospital or institution, give street address or location): 4940 Eastern Avenue Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 27-44
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3600 Keene Avenue #21214

31

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	9-21-80	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman		Maryland	U. S. A.

13. FATHER'S NAME: John Sommer

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		216030150	RECORDS: B.C.H.	4940 Eastern Avenue #21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: Many Years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

DUE TO (B) Chronic Brain Syndrome — Years

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Pneumonitis — few days

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from 5-21- 19 65 to 5-23 19 65, that (I) (we) last saw the deceased alive on 5-23- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
C.C. Carpenter M.D.	Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒	5-23-65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Dr. Charles Carpenter M.D.	4940 Eastern Avenue #21224

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	5-26-65	Moreland Mem. Park	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 24 1965	Robert E. Farley M.D.	Leonard J. Ruck Inc Baltimore, Md.

VS 150-REV. 1/1/65

1

P-400

65 5480

BALTIMORE CITY HEALTH DEPARTMENT

65 5480

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): COURTNEY J. POOLE

2. DATE AND HOUR PRONOUNCED DEAD: May 22, 1965 1:25 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-01
D. STREET ADDRESS (If rural, give location): 1515 Park Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
male	white	Divorced	12-18-1891	73				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Guard		Maryland	USA

13. FATHER'S NAME: Richard H. Poole

14. MOTHERS MAIDEN NAME: Josephine M. Courtney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
yes	WW 1		Richard H. Cunningham 147 Stanmore Rd.

MEDICAL CERTIFICATION

18. 163X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Chronic lung disease (History of lung cancer)
DUE TO

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 5-23-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
burial	5-25-65	New Cathedral Cem.	Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 24 1965	Robert E. Foster	Leonard J. Ruck Inc Baltimore, Md.

VS 151-REV. 1/1/65

L-532 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5481 Registered No. 65 5481

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Ernest C. Lindsey

2. DATE AND HOUR OF DEATH: May 23, 1965 12:45 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3003 Harview Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 2705
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3003 Harview Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
male	white	married	June 3, 1887	77				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Carpenter		Missouri	USA

13. FATHER'S NAME: George Lindsey

14. MOTHER'S MAIDEN NAME: Sarah Eckard

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	514097716	Effie May Lindsey	same

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.1 I

CAUSE OF DEATH

(A) DUE TO: Acute coronary thrombosis

(B) DUE TO: Arteriosclerotic C-V disease

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH: 30 min

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary edema

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Jan. 8 1949 to May 23 1965, that (I) (~~not~~) last saw the deceased alive on May 22 1965 and that in(my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys.	Med. Director	Staff Phys.	23B. DATE SIGNED
H. V. Harbold		☒	☐	☐	May 24, 1965

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
H. V. HARBOLD		4706 Harford Rd Baltimore Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	5/26/65	Moreland Mem. Park	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 24 1965	Robert E. Farley, M.D.	Leonard J. Ruck Inc Baltimore, Md.

VS 1S0-REV. 1/1/6S

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-450 1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. 65 5482 Registered No. 65 5482

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Anna (Annie) M. Klein

2. DATE AND HOUR OF DEATH: MAY 23, 1965 | 10 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 3208 Springdale Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3208 Springdale Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
female	white	widowed	11-21-1877	87				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home	~~XXXXXXX~~ Maryland	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Seifert	Augusta

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Mrs Thelma Schwartz	930 Cator Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 334 X 1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not meon the mode ol dying, e.g., heort foilure, osthenio, etc. It meons the diseose, injury or complicotion which coused deoth.)

(A) DUE TO: General and cerebral arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: Several years

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if ony, giving rise to the obove couse (A) stoting the UNDERLYING CONDITION lost.

(B) DUE TO:

(C):

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exomined)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Boltimore City, give exoct locotion)

21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from March 8 19 64 to May 23 19 65, that (I) (~~we~~) last saw the deceased alive on May 19 19 65 and that in(my) (~~our~~) opinion death occurred on the date and haur and from the causes stated obave. (I) (We) (~~did~~) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☑	Med. Director ☐	Staff Phys. ☐	23B. DATE SIGNED
Louis E. Wice					5/24/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Louis E. WICE		920 ST. PAUL ST.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	5-26-65	Loudon Park Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robt E. Farley M.D.	Leonard J. Ruck Inc	Baltimore, Md.

VS 150-REV. 1/1/65

1

A-400

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 65 5483 Registered No. 65 5483

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EARL LEROY HEIL

2. DATE AND HOUR PRONOUNCED DEAD: May 23, 1965 | 9:30 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 2908 Echodale Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-03
D. STREET ADDRESS (If rural, give location): 2908 Echodale Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
male	white	single	9-25-1916	48		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Barber		Maryland	USA

13. FATHER'S NAME: Frederick C. Heil

14. MOTHER'S MAIDEN NAME: Carrie M. Snyder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes WW 2	212012534	Mrs Carrie M. Heil	same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease 4221

DUE TO

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breitenecker M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 5-23-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
burial	5-26-65	Moreland Mem. Park	Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 24 1965	Robert E. Farley, M.D.	Leonard J. Ruck Inc Baltimore, Md.

VS 151-REV. 1/1/65

L-550 1

BIRTH NO. 65 5484

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5484

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Lemon, Coleman, Sr.

2. DATE AND HOUR OF DEATH: May 23, 1965 | 2:25 p.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): St. Joseph Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 27-44
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #14
D. STREET ADDRESS (If rural, give location): 3206 White Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	8-8-12	52		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Painter	Coleman's Painting & Decorating	Gloucester, Va.	USA

13. FATHER'S NAME: William Lemon

14. MOTHER'S MAIDEN NAME: Luemma Harris

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		Catherine A. Lemon	same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) ACute myocardial infarction
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(B)
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 23, 1965 to May 23, 1965, that (I) (we) last saw the deceased alive on May 23, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: May 23, 1965

23C. PHYSICIAN'S NAME (Type): Anastacio E. Subong, Jr. M.D.

23D. ADDRESS: 1400 N. Caroline St., 21213

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	5-26-65	Parkwood Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 24 1965	Robert E. Farley, M.D.	Leonard J. Ruck Inc Baltimore, Md.

VS 150-REV. 1/1/65

C-2601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5485 Registered No. 65 5485

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Minnie C. ~~Casciero~~ CASCIERO

2. DATE AND HOUR OF DEATH: May 21, 1965. 2:57 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address)

CERTIFICATE CORRECTED 5/28/65

3012 Chesterfield Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: 26-03

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore Md.

D. STREET ADDRESS (If rural, give location): 3012 Chesterfield Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Widow	Nov. 22, 1902	62				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Italy	USA

13. FATHER'S NAME: Antonio Donatelli

14. MOTHER'S MAIDEN NAME: Adeline Rossi

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Anthony Casciero ADDRESS: Kingsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
(A)	Acute Cardiac Decompensation	15 years
DUE TO		
(B)	Mitral & Aortic Stenosis & Insufficiency	15 years
DUE TO		
(C)	Rheumatic Cardiac Valvular Disease	4 years

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT, WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 12/8 1953 to 5/21 1965, that (I) (we) last saw the deceased alive on 5/20 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Melvin F. Polek M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 5/22/65

23C. PHYSICIAN'S NAME (Type): MELVIN F. POLEK M.D.

23D. ADDRESS: 3603 Belair Rd Balto. Md.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-24-65	Holy Redeemer Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: MAY 24 1965 Robert E. Tawney

25B. NAME OF REGISTRAR:

25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc. ADDRESS: Balto 14 Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

vs 153 signed by funeral director. C. B. 5/28/65

1

B-530

BALTIMORE CITY HEALTH DEPARTMENT

65 5486

BIRTH NO. 65 5486 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) TILDON Samuel BENNETT	2. DATE AND HOUR PRONOUNCED DEAD May 19, 1965 | 6:50 P M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Joseph's Hospital	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 9-03 D. STREET ADDRESS (If rural, give location) 3512 Ellerslie Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	married	8-8-1876	88		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Sanitation Engineer		Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Samuel Bennett	Not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	217016633A	Agnes R. Elfrey	same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease. — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fracture of Femur

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Street	Greenmount and North Avenues

21D. TIME OF INJURY (APPROX.) (Month)	(Day)	(Year)	(Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
4	16	'65	P m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Fell while alighting from bus.

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles Petty M.D.
EXAMINER'S NAME (Type) Charles S. Petty, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED 5/20/65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
burial	5-22-65	Meadowridge Cemetery	Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
MAY 24 1965	Robert E. Farley, M.D.	Leonard J. Ruck Inc Baltimore, Md.

VS 151-REV. 1/1/65

N 821.0

5-536 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5487 Registered No. 65 5487

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Snyder, Harry T.

2. DATE AND HOUR OF DEATH: May 21, 1965 | 12:10 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give streot oddross or locotion): St. Joseph Hospital

4. USUAL RESIDENCE (Whero docoosed lived. If institution: rosidence bofore odmission)

A. STATE: Maryland B. COUNTY: 27-01

C. CITY OR TOWN (If outside city limits, write RURAL ond give township): Baltimore 21206

D. STREET ADDRESS (If rurol, givo locotion): 3713 Ridgecroft Rd.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In yeors lost birthdoy)	If Under 1 Yr. Months	Doys	If Under 24 Hrs. Hours	Min.
Male	White	Married	11-12-1888	76				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Lumber Business	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Calvin P. Snyder	Mollie E. Wentz

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW 1	578-09-2931	Mrs. Anna J. Snyder	(Same)

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
1B. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Congestive heart failure ~~xxxxx~~ secondary to acute myocardial infarction	
	(B) Probable pulmonary infarction DUE TO	
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(C) Probable right lower lobe pneumonia	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

MEDICAL CERTIFICATION

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 19, 1965 to May 21, 1965, that (I) (we) last saw the deceased alive on May 21, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☒	23B. DATE SIGNED
[signature]					May 21, 1965

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Anastacio E. Subong, Jr.		1400 N. Caroline St., Baltimore, Md. 21213

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/25/65.	Baltimore National Cem.	Baltimore, Md.

25A. DATE RECD BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 24 1965	Robert E. Farley M.D.	Leonard J. Ruck Inc.	Balto 14 Md.

VS 150-REV. 1/1/65

S-5301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5488 Registered No. 65 5488

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Robert A. Schmidt

2. DATE AND HOUR OF DEATH: May 21, 1965 | 3:40 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2207 Pelham Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 8-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2207 Pelham Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
male	white	married	Oct. 6 1905	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Employee	Martin Co.	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George E. Schmidt	Anna Lohman

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	215051647	Martha L. Schmidt	same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CIRHOSIS OF THE LIVER - PORTAL TYPE
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(B)
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH
(A) 12 YEARS
(B)
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
OSTEOCHONDRITIS DESICANS BILATERAL, HIPS
12 YEARS +

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (~~this hospital~~) attended the deceased from May 18 1965 to May 21 1965, that (I) (~~we~~) last saw the deceased alive on May 20 1965 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
W. Alfred Gakenheimer, M.D.	Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐	5/21/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
W. ALFRED GAKENHEIMER M.D.	3805 BELAIR ROAD BALTIMORE, MARYLAND 21213

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	5/24/65	Green Mount Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 24 1965	Robert E. Farley, M.D.	Leonard J. Ruck Inc Baltimore, Md.

VS 150-REV. 1/1/65

S-550 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5489 Registered No. 65 5489

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Simon, Joseph

2. DATE AND HOUR OF DEATH 5-21-65 7:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

43 South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY 24-01

C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 1428 Haubert St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	Widowed	7/3/1905	59				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Upholsterer	----------	Maryland	U.S.A.

13. FATHER'S NAME Jacob Simon

14. MOTHER'S MAIDEN NAME Hildebrant

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	World War II	215-07-4045	Evelyn Simon	1428 Haubert St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
1B. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Myocardial Infarction DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(B) ASCVD DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-17-1965 to 5-21-1965, that (I) (we) last saw the deceased alive on 5-21-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☑	23B. DATE SIGNED
Kermit P. Bonovich					5/21/65

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
Kermit P. Bonovich		213 Light St. Balto., Md 21230.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/24/65	Cedar Hill Cemetery	Anne Arundel, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
MAY 24 1965	Robert E. Farkey M.D.	Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-130 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5490 Registered No. X 65 5490

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Walter Nevitt

2. DATE AND HOUR OF DEATH: 5/21/65 10:40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddess or location): University

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Carroll
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Sykesville 5-00
D. STREET ADDRESS (If rural, give location): Oakland Mill Rd.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	Married	7/18/86	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	maintenance	Indiana	U.S.A.

13. FATHER'S NAME: Thomas Nevitt

14. MOTHER'S MAIDEN NAME: Floretta Davis

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): W W 1

16. SOCIAL SECURITY NO.: 212 09 8784

17. INFORMANT: Naomia Nevitt ADDRESS: Oakland Mills Rd. Bx 67 Sykesville, Md.

MEDICAL CERTIFICATION

18. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not meon the mode of dying, e.g., heart foilure, asthenio, etc. It means the diseose, injury or complicatian which coused deoth.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if ony, giving rise to the above couse (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: Myocardial Infarction
(B) DUE TO: ASCVD
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
—		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol exominer)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Doy) (Yeor) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/21 1965 to 5/21 1965, that (I) (we) last saw the deceased alive on 5/21 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Jonathan Tuerk M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 5/21/65

23C. PHYSICIAN'S NAME (Type): Jonathan Tuerk M.D.

23D. ADDRESS: University Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	5 25 1965	Meadowridge Mem. Cem.	Washington Blvd., Howard Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: MAY 25 1965

25B. NAME OF REGISTRAR: Robert E. Faherty

25C. FUNERAL DIRECTOR: Loring Byers, 8728 Liberty Rd. Randallstown Md. 21133 ADDRESS

VS 150-REV. 1/1/65

D-52.01

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5491 Registered No. 65 5491

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): DOWNS ANN

2. DATE AND HOUR OF DEATH: 5/21/65 7:25 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSP

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: AA
C. CITY OR TOWN (If outside city limits, write RURAL and give township): ODENTON 62-00
D. STREET ADDRESS (If rural, give location): 481 MONTEREY AVE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	Widow	1-17 1882	83		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework (ret.)	Own Home	Harmons, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Hezekiah Jeffrey	Sarah M. Wade

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no / / / / / / / / /	none	Mr. William Downs(son)	Lombard, Illinois

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Aortic Aneurysm Dissection — INTERVAL BETWEEN ONSET AND DEATH: 5 Hours?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/21/65 AM 1965 to 5/21 1965, that (I) (we) last saw the deceased alive on 7:20 AM 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
Dominic A Cicotta M.D.	Attending Phys. ☒ Med. Director ☐ Staff Phys. ☒	5/21/65

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
DOMINIC A. CICOTTA M.D.	UNIVERSITY

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	May 24/65	Friendship Cemetery	Anne Arundel Co., Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 25 1965	Robert E. Fabian, M.D.	R.V. Singleton,	Glen Burnie, Md.

VS 150-REV. 1/1/65

T-440

1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5492 Registered No. 65 5492

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): TAYLOR, JAMES M.

2. DATE AND HOUR OF DEATH: MAY 21, 1965 4:50 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location): ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE 29, MARYLAND

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: Anne Arundel

C. CITY OR TOWN (If outside city limits, write RURAL and give township): PASADENA

D. STREET ADDRESS (If rural, give location): BOX 442 ROUTE 9

32-00

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
MALE	WHITE	MARRIED	4-7-12	53				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SELF EMPLOYED	Plumbing & Heat.	BALTIMORE, MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
EDWARD TAYLOR	FLORENCE ELLENSWORTH

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
UNKNOWN XXXXXXXXX	NO	218 10 3752	ST. AGNES HOSPITAL,	WILKENS & CATON AVE.

MEDICAL CERTIFICATION

18.	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart foilure, asthenio, etc. It means the disease, injury or complicatian which caused deoth.) 420.1 I	(A) Cardiac Arrest	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above couse (A) stating the UNDERLYING CONDITION last.	DUE TO (B) Acute Miocardial Infarction	
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol examiner)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify thot (I) (this hospitol) ottended the deceased from MAY 19 1965 to MAY 21 1965, thot (I) (we) lost saw the deceased alive on MAY 21 1965 and that in (my) (our) opinion deoth occurred on the dote ond hour and from the couses stoted obove. (I) (We) (did) (did not) view the body ofter deoth.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 5-21-65

23C. PHYSICIAN'S NAME (Type): MIGUEL A. HEREDIA M.D.

23D. ADDRESS: ST. AGNES HOSPITAL, WILKENS & CATON AVE. N

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	May 25/65	Glen Haven Memorial Park	Glen Burnie, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 25 1965	Robert E. Parker, M.D.	R.V. Singleton,	Glen Burnie, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-1081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5493 Registered No. 65 5493

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): KAY LEAH LOVE

2. DATE AND HOUR OF DEATH: 20 May 65 | 12:40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital 34

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY: City 15-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township): 1532 N. Smallwood St (16) city
D. STREET ADDRESS (If rural, give location)

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	widowed	6-10-1895	69				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	AT HOME	Balto. Md	USA

13. FATHER'S NAME: Max Kimel

14. MOTHER'S MAIDEN NAME: Selda Kunic

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO			MRS. Zelda Zeltzoff	2321 Micheol Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) adeno carcinoma, — INTERVAL BETWEEN ONSET AND DEATH
DUE TO Generalized metastasis abdomen
(B) Myocardiac infarction
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
3 May 1965		YES	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8 May 19 65 to 20 May 19 65, that (I) (we) last saw the deceased alive on 20 May 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Jos Hipolito M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ — 23B. DATE SIGNED: 20 May 65

23C. PHYSICIAN'S NAME (Type): J. M. HIPOLITO M.D. — 23D. ADDRESS: Bon Secours Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/27/65	Mikro Kodesh Beth Israel	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 25 1965	Robert E. Faber, M.D.	Sol Levinson & Bros. Inc.	6010 Reisterstown Rd.

VS 150-REV. 1/1/65

M-614 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5494 Registered No. 65 5494

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CARLYN LOBE MERFELD

2. DATE AND HOUR OF DEATH: MAY 20, 1965 3:30 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2007 SULGRAVE AVENUE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 2215
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2007 SULGRAVE AVE.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	WHITE	WIDOWED	1/17/1904	61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	AT HOME	BALTIMORE MARYLAND	U.S.A.

13. FATHER'S NAME: HARRY G. LOBE

14. MOTHER'S MAIDEN NAME: MINNA ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		MR H. JOHN LOBE	10 STURGIS COURT

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) DUE TO: Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
(B) DUE TO: Arteriosclerosis — 8 years

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 2 years 19 ____ to 20 May 19 65, that (I) (~~we~~) (~~last~~) saw the deceased alive on May 11 1965 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (~~I~~) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Louis H. Hamburger Jr. M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 21 May 1965

23C. PHYSICIAN'S NAME (Type): DR. LOUIS HAMBURGER, JR. M.D.

23D. ADDRESS: 1001 ST. PAUL ST.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
CREMATION + BURIAL	5/23/65	LOUDON PARK CREMATORY Oheb Shalom Cong Cemetery	BALTIMORE MARYLAND

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 25 1965	Robert E. Faulkner	SOL LEVINSON + BROS. INC.	6010 REISTERSTOWN RD.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-323 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5495 Registered No. 65 5495

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Rotstein, Rebecca

2. DATE AND HOUR OF DEATH: 5/23/65 | 2:30 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or locotion): Sinai Hospital of Balto.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balto. 2-19
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 5535 Gist Ave #15

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow.
8. DATE OF BIRTH: 12/10/80
9. AGE (In years last birthday): 84
If Under 1 Yr. Months / Days; If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Raphael Goldschnidt
14. MOTHER'S MAIDEN NAME: Esther Gottlieb

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Helen R. Goldsmith
ADDRESS: 4003 Barrington Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary edema

DUE TO

(B) Coronary Insufficiency

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C) HASC VD

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

C.V.A

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/28/65 19 to 5/23/65 19, that (I) (we) last saw the deceased alive on 5/22/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Thomas L. Feher M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 5/23/65
23C. PHYSICIAN'S NAME (Type): THOMAS L. FEHER M.D.
23D. ADDRESS: Sinai Hospital of Balto

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 5/23/65
24C. NAME of CEMETERY or CREMATORY: Tifereth Israel Anshe Sfard
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: MAY 25 1965
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc.
ADDRESS: 600 East Lexington St.

VS 150-REV. 1/1/65

1

R-150

65 5496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO.

Registered No. 65 5496

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Thomas A. Rubin

2. DATE AND HOUR OF DEATH: May 23, 1965 | 2:35 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY: 3010 - Glen The 21220
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15, Maryland
D. STREET ADDRESS (If rural, give location):

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
MALE	WHITE	MARRIED	4/22/1913	52				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETAIL	GROCER	BALTIMORE, MARYLAND	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
UNKNOWN	UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		215-09-1789	MRS. ROSE RUBIN	3010 GLEN AVENUE

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
1B. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) DUE TO: Acute Coronary Thrombosis	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(B) DUE TO:	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ____ 19 ____ to May 23 1965, that (I) (we) last saw the deceased alive on May 23 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (~~did~~) (did not) view the body after death.

23A. SIGNATURE		23B. DATE SIGNED
Nathan E. Needle M.D.	Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐	

23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
NATHAN E. NEEDLE M.D.	4215 - Park Heights Ave

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
BURIAL	5/25/65	MOSES MONTIFIORE WOODMOOR HEBREW	BALTIMORE	MARYLAND

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 25 1965	Robert E. Farley, M.D.	SOL LEVINSON & BROS. INC.	6010 REISTERSTOWN RD

VS 150-REV. 1/1/65

42-12-99 LS 1

P-566

BIRTH NO. 65 5497

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 5497

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): William Payne

2. DATE AND HOUR OF DEATH: May 21, 1965 | 9:10 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 13-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2244 Madison Avenue #21217

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Negro	Single	7-22-05	59				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William Payne
14. MOTHER'S MAIDEN NAME: Elizabeth Newston

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: RECORDS: B.C.H. 4940 Eastern Avenue #21224 ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Renal Failure — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(B) Bilateral Hydronephrosis
DUE TO
(C) Carcinoma of the Bladder

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-9- 19 65 to 5-21- 19 65, that (I) (we) last saw the deceased alive on 5-21 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Kenneth N. Walton M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 5-21-65
23C. PHYSICIAN'S NAME (Type): Dr. Kenneth N. Walton M.D.
23D. ADDRESS: 4940 Eastern Avenue #21224

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/25/65	St Luke Cem.	Reisterstown, Md.

25A. DATE REC'D BY HEALTH DEPT.: MAY 25 1965
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: George A. Kelly ADDRESS: 1348 N. Calhoun St

VS 150-REV. 1/1/65

K-400 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5498 Registered No. 65 5498

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): KELLY, ROBERT. L.

2. DATE AND HOUR OF DEATH: May-23, 1965 | 10 1965 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): LUTHERAN HOSPITAL of Md. 3209 PIEDMONT AVE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND. B. COUNTY: 15-37
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location):

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M.	N.	Married	3-5-06	59				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
UNEMPLOYED.		Maryland	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Lewis Kelly	Harrette Kelly

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO.		Alice Kelly	3809 Piedmont AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not meon the mode of dying, e.g., heort foilure, osthenio, etc. It meons the diseose, injury or complicotion which coused death.)

(A) DUE TO: C. V. A. — INTERVAL BETWEEN ONSET AND DEATH: 3 wks.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if ony, giving rise to the obove couse (A) stoting the UNDERLYING CONDITION lost.

(B) DUE TO:

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
O			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medicol examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 4 1965 to May 23 1965, that (I) (we) last saw the deceased alive on May 23 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE	M.D.	Attending Phys. ☐	Med. Director ☐	Staff Phys. ☑	23B. DATE SIGNED
Joon S. Lee					May 23, 1965

23C. PHYSICIAN'S NAME (Type)	M.D.	23D. ADDRESS
JOON SUECK LEE		LUTHERAN HOSPITAL OF Md.
Joon Sueck Lee		

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5-26-65	New Cat. Cem.	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 25 1965	Robert E. Farley, M.D.	George A. Kelso	1548 N. Calhoun St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

5-530

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 65 5499 Registered No. 65 5499

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): NATHANIEL SMITH

2. DATE AND HOUR PRONOUNCED DEAD: May 23, 1965 | 4:49 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Provident Hospital

39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-02
D. STREET ADDRESS (If rural, give location): 909 N. Parrish St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
male	colored	Never Married	1-9-55	10		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md.	U. S. A

13. FATHER'S NAME: James Tadley

14. MOTHER'S MAIDEN NAME: Mary Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		Mary Thomas	125 Culver St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

E916.0

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Smoke inhalation with carbon monoxide poisoning.

ANTECENDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B)

DUE TO (C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	No

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Home	909 N. Parrish St. 16-02

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
5 23 65 4:22a m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Caught in house fire of home.

22. I certify that I held an Inquiry [ ] Inspection [X] Autopsy [ ] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 5-23-65

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	5-26-65	Mt Auburn Cem.	Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAY 25 1965	Robert E. Faber M.D.	George A. Liles	1348 N. Calhoun St.

VS 151-REV. 1/1/65

N968.0

H-1553 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 65 5500 Registered No. 65 5500

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Sarah E. Herndon

2. DATE AND HOUR OF DEATH: May 21, 1965 | 8:15 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 2120 Mulberry St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY 20-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2120 W. Mulberry St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	Negro	Widowed	Aug. 12, 93	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		S.C.	U.S.A.

13. FATHER'S NAME: Robert Alexander

14. MOTHER'S MAIDEN NAME: Alice

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Fedora Brooks	2120 W. Mulberry St.

MEDICAL CERTIFICATION

18. 4221 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH: Arteriosclerotic Cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 9 years
DUE TO
(B) DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from February 1956 to May 21 1965, that (I) (we) last saw the deceased alive on May 14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: William H Watts M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐ — 23B. DATE SIGNED: 5-24-65

23C. PHYSICIAN'S NAME (Type): William H. Watts M.D. — 23D. ADDRESS: 515 N Arlington Ave Reisterstown Md

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	5/28/65	Church Cem.	Chester S.C.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAY 25 1965	Robert E. Fabian, M.D.	George A. Kelso	1548 N. Calhoun St

VS 150-REV. 1/1/65